STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601036	A. BUILDING: _____ B. WING _____	R 03/09/2023

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BARNABAS	19704 ZION AVENUE CORNELIUS, NC 28031

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 3/9/23. The complaints were substantiated (Intake #NC00195680, #NC00196561, #NC00196741). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid	V 108	DHSR - Mental Health APR 13 2023 Lic. & Cert. Section	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

, Director of Quality Management 4/5/23

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V 108	Continued From page 1 techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure training in client rights and confidentiality, infectious diseases and bloodborne pathogens, meeting the mh/dd/sa needs of the clients, affecting 4 of 4 staff(#1, #2, Residential Manager and Qualified Professional). The findings are: Review on 2/28/23 of Staff #1's personnel record revealed: - Date of Hire 6/17/19; - No training in client rights and confidentiality; - No training to meet the mh/dd/sa needs of the clients. Review on 2/18/23 of Staff #2's personnel record revealed: - Date of Hire 7/20/20; - No training in client rights and confidentiality; - No training to meet the mh/dd/sa needs of the clients; - No training in bloodborne pathogens. Review on 2/28/23 of the Residential Manager's personnel record revealed:	V 108	Residential Manager, Qualified Professional and Staff # 1 and 2 will be re-trained on April 9-11, 2023. Copies of their training certificates will be kept in their employee files and their trainings will be uploaded in our electronic database.	4.11.23

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V 108	Continued From page 2 - Date of Hire 6/15/04 - No training in client rights and confidentiality; - No training to meet the mh/dd/sa need of the clients. Review on 2/28/23 of the Qualified Professional's personnel record revealed: - Date of Hire 8/8/22; - No training in client rights and confidentiality; - No training to meet the mh/dd/sa needs of the clients. Interview on 2/2/23 with staff #1 revealed: - All trainings were up to date. Interview on 2/27/23 with Staff #2 revealed: - All trainings were up to date. Interview on 2/28/23 with the Residential Manager revealed: - The staff "normally" in charge of trainings no longer work for agency; - There was a "lot" of staff turnover; - Human Resources Director, who can schedule training and has access to the staff's personnel record, started a few weeks ago. Interview on 3/1/23 with the Human Resources Director revealed: - Started with the Licensee approximately 3 weeks ago; - Had over 300 items(records and miscellaneous papers) to sort through; - Pulled personnel records and all the trainings on the requested staff for survey that was seen thus far.	V 108		

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V 115	Continued From page 3	V 115		
V 115	27G .0208 Client Services 10A NCAC 27G .0208 CLIENT SERVICES (a) Facilities that provide activities for clients shall assure that: (1) space and supervision is provided to ensure the safety and welfare of the clients; (2) activities are suitable for the ages, interests, and treatment/habilitation needs of the clients served; and (3) clients participate in planning or determining activities. (h) Facilities or programs designated or described in these Rules as "24-hour" shall make services available 24 hours a day, every day in the year. unless otherwise specified in the rule. (c) Facilities that serve or prepare meals for clients shall ensure that the meals are nutritious. (d) When clients who have a physical handicap are transported, the vehicle shall be equipped with secure adaptive equipment. (e) When two or more preschool children who require special assistance with boarding or riding in a vehicle are transported in the same vehicle, there shall be one adult, other than the driver, to assist in supervision of the children. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure meals were nutritious. The findings are: Observation on 2/2/23 at 1:00pm of the facility's	V 115		

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V 115	Continued From page 4 food revealed: -The refrigerator had one original store packaged lunch meat labeled as smoked ham and smoked turkey with a green substance on the meat and an expiration date of 1/9/23 on the package; - Cheese slices stored in the original package with an expiration date of 1/17/23; - 4 slices of Bologna in a plastic sandwich bag with white slim substance and no label; - Promise Land Old Fashioned Egg Nog with an expiration date of 1/22/23; - In the kitchen cabinet were hot dog buns with an expiration date of 1/18/23; Interview on 2/2/23 with client #1 revealed: - Fixed own food; - Food was "old" and "spoiled with green spot on it"; - Food was often spoiled; - Did not report to staff when seen spoiled food in the refrigerator. Interview on 2/27/23 with client #2 revealed: - Do not get a balanced meal; - Green spots on lunch meat and threw it away; - Did not report to staff about the lunch meat having spots on it. Interview on 2/27/23 with client #3 revealed: - Threw away food after being in the refrigerator too long; - Did not see "expired" lunch meat in the refrigerator. Interview on 1/17/23 and 2/1/23 with the legal guardian of client #1 revealed: - On 1/5/23, seen "mold" on lunch meat (ham) when visiting client #1; - "I picked up one sandwich and seen there was mold on the lunch meat, I then looked at the other	V 115	Residential Manager has implemented a cleaning schedule for direct care staff to follow that includes cleaning out the refrigerator. Residential Manager and Qualified Professional Met with the Director of Quality Management and Chief Programs and Quality Management Officer and Sanitation Guidelines and expectations were reviewed. Residential Manager will review guidelines and expectations with the	4.3.23

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V 115	Continued From page 5 sandwich seen the meat had mold on it." - Informed Staff #1 the lunch meat was "moldy" and client #1 could not eat the lunch meat; - Staff #1 stated she would clean out the refrigerator; - The expired lunch meat from January 2023 was still in the refrigerator on 2/1/23 when she went to the home. Interview on 2/2/23 with Staff #1 revealed: - Clients packed their own lunches; - Cooked balanced meals for all the clients; - Checked food at the start of shift every other Wednesday; - "Short staffed, so I try my best to do what I can do." Interview with Staff #2 revealed: - Cooked balanced meals for clients; - Did not observe any spoiled food in the refrigerator. Interview on 2/2/23 and 3/9/23 with the Residential Manager revealed: - Started working in the home on 1/3/23; - Unaware of any spoiled or expired food in the home; - Planned to have staff check food weekly; - "We are purchasing more healthier things for clients."	V 115	Direct Care Staff at the upcoming Staff Meeting.	
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe	V 118		

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V 118	Continued From page 6 drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure medications were administered by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person affecting 2 of 4 audited staff (#1, #2). The findings are: Review on 2/28/23 of Staff #1's personnel record	V 118	Staff # 1 and # 2 Will complete Medication Administration training on Tuesday April 10th 4.10.23	

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V 118	Continued From page 7 revealed: - Date of Hire 6/17/19; - No record of medication administration training in personnel file. Review on 2/28/23 of Staff #2's personnel record revealed: - Date of Hire 7/20/20; - No record of medication administration training in personnel file. Interview on 2/2/23 with staff #1 revealed: - Administered medication; - All trainings were up to date. Interview on 2/27/23 with Staff #2 revealed: - Administered medication; - All trainings were up to date. Interview on 2/28/23 with the Residential Manager revealed: - The staff normally in charge of trainings no longer work for agency; - There was a lot of staff turnover; - Human Resources Director, who can schedule training and has access to the staff's file, started a few weeks ago. Interview on 3/1/23 with the Human Resources Director revealed: - Started with the Licensee approximately 3 weeks ago; - Had over 300 items(records and miscellaneous papers) to sort through; - Pulled personnel records and all the trainings on the requested staff for survey that was seen thus far.	V 118	At UMAR's Central Office.	

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V 290	Continued From page 8	V 290		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on	V 290		

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V 290	Continued From page 9 duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure staff were always present with clients except when the client's treatment plan documented they were capable of remaining in the community or the facility for 1 of 3 clients (#1). The findings are: Review on 2/2/23 of client #1's record revealed: - Admission date 7/10/21; - Diagnoses: Down Syndrome, Moderate Intellectual Disabilities; -There was no documentation that client #1 had been assessed to support the Consent for Unsupervised Group Home/community Stays of 5 hours of unsupervised time in the group home dated 6/26/21. - No documentation on unsupervised time in his Individual Support Plan dated 7/10/22. Interview on 2/2/23 with client #1 revealed: - Stated sometimes left alone in the group home; - Felt safe when in the home alone. Interview on 1/17/23 and 3/8/23 with client #1's legal guardian revealed: - Decided when client #1 moved into the group home, he could have alone time during the day on Mondays and Tuesdays from 10am-2pm	V 290	Client #1 now has current Consents signed and in his resident record that specify that amount of time and when he is able to have unsupervised time at home and community.	

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V 290	Continued From page 10 since there was no staff able to supervise him on these days.ondays; - Client #1 did not have an assessment before legal guardian signed a consent on 6/26/21 giving permission for alone time in the group home; - Client #1's alone time in the group home was never added to his treatment plan; - Client #1's new "treatment plan" dated 2/1/23 does not allow alone time. Interview on 2/28/23 with the Qualified Professional revealed: - Started in "August" and still learning what duties need to be completed and records updated; - Continued to follow daily routine of what was "in placed" when started employment; - Staff was at the home now with client #1 during the day.	V 290		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and	V 366		

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V 366	Continued From page 11	V 366		

preventive measures;
(6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and
(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.
(b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.
(c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by:
(1) immediately securing the client record by:
(A) obtaining the client record;
(B) making a photocopy;
(C) certifying the copy's completeness; and
(D) transferring the copy to an internal review team;
(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:
(A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the

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V 366	Continued From page 12 occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law.	V 366		

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V 366	Continued From page 13 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement, written policies governing their responses to level I, II and III incidents affecting 1 of 3 audited clients(#1). The findings are: Review on 1/17/23 of Incident Response Improvement System (IRIS) from 10/17/22-1/17/23 revealed: -No IRIS report, Risk Cause/Analysis , or documentation to support submission of the written preliminary findings of fact to the Local Management Entity (LME)/ Managed Care Organization (MCO) within 5 working days for client #1 being picked up by the wrong agency from group home approximately 7/22/22. Interview on 1/17/23 and 2/8/23 with legal guardian of client #1 revealed: -Client #1 was picked up by the wrong agency from the group home on approximately7/22/22; - Unsure of what staff was in the home when the incident of client #1 was picked up by wrong agency on approximately 7/22/22; - Staff #2 was home and looking out the window when client #1 got in the car with the wrong agency on approximately 7/22/22; -"Had conference call with [Former Staff #5] and care coordinator but there was no follow up about what was done to the staff or if an incident report was made to the State." Interview on 2/27/23 with Staff #2 revealed: - "I don't recall being here at facility when that(client #1 being picked up by the wrong	V 366	Residential Manager and Qualified Professional were trained on IRIS-I/A reporting. Residential Manager and Qualfied Professional will review I/A reporting at the upcoming staff Meeting. 4/3/23	

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V 366	Continued From page 14 agency) happened." Interview on 3/3/23 with Former Staff #5 revealed: - Was informed by client #1's legal guardian, that client #1 had been picked from the group home by the wrong agency; - Staff #2 was on schedule but incident (client #2 picked up by the wrong agency) happened during staff #2's off shift time between 10am-2pm; - Had a conference call with the legal guardian of client #1, care coordinator and upper management and it was determined that [Licensee] was not at fault. - There was no written incident report, or documentation of the meeting due to [Licensee] not being at fault. Interview on 2/8/23 with the Facility Director of Clinical Services revealed: - Unable to locate any incident reports regarding client #1 being picked up by the wrong agency; - Staff who would had access to incidents reports or who would have written up the incident report is no longer employed with Licensee.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where	V 367		

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V 367	Continued From page 15 services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A	V 367		

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V 367	Continued From page 16 providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report all critical incidents in the	V 367		

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V 367	Continued From page 17 Incident Response improvement System (IRIS) and notify the Local Management Entity (LME)/Managed Care Organization (MCO) responsible for the catchment areas where services were provided within 72 hours of becoming aware of the incident affecting 1 of 2 clients. The findings are: Review on 2/2/23 of the facility's records revealed: -No documentation of the LME/MCO notification of incident occurred approximately 7/22/22. Interview on 1/17/23 and 2/8/23 with legal guardian of client #1 revealed: - Client #1 was picked up by the wrong agency from the group home on approximately 7/22/22; - Unsure of what staff was in the home when the incident of client #1 was picked up by wrong agency on approximately 7/22/22; - Staff #2 was home and looking out the window when client #1 got in the car with the wrong agency on approximately 7/22/22; -"Had a conference call with [Former Staff #5] and care coordinator but there was no follow up about what was done to the staff or if an incident report was made to the State." Interview on 2/27/23 with Staff #2 revealed: - "I don't recall being here at facility when that (client #1 being picked up by wrong agency) happened." Interview on 3/3/23 with Former Staff #5 revealed: - Was informed by client #1's legal guardian, that client #1 had been picked from the group home by the wrong agency; - Staff #2 was on the schedule but incident (client #1 being picked up by the wrong agency)	V 367	Residential Manager and Qualified Professional met with the Director of Quality Management and Chief Programs and Quality Officer and reviewed Incident reporting guidelines and when a critical incident needs to be reported via IRIS.	

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V 367	Continued From page 18 happened during staff #2's off shift time between 10am-2pm; - Had a conference call with the legal guardian of client #1, care coordinator and upper management and it was determined that [Licensee] was not at fault. - There was no written incident report, or documentation of the meeting due to [Licensee] not being at fault. Interview on 2/8/23 with the Facility Director of Clinical Services revealed: - Unable to locate any incident reports regarding client #1 being picked up by the wrong agency; - Staff who would had access to incidents reports or who would have written up the incident report is no longer employed with Licensee.	V 367		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data	V 536		

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V 536	Continued From page 19 gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace	V 536		

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V 536	Continued From page 20 behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience	V 536		

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V 536	Continued From page 21 teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on the record review and interview, the	V 536		

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V 536	Continued From page 22 facility failed to ensure annual training in alternatives to restrictive interventions prior to providing services affecting 1of 2 staff (#2). The findings are: Review on 2/28/23 of Staff #2'a personnel record revealed: - Date of Hire 7/20/20; - No record of training in alternative restrictive interventions. Interview on 2/27/23 with Staff #2 revealed: - All trainings were up to date. Interview on 2/28/23 with the Residential Manager revealed: - The staff "normally" in charge of trainings no longer work for agency; - There was a "lot" of staff turnover; - Human Resources Director, "who can schedule training and has access to the staff's personnel record, started a few weeks ago." Interview on 3/1/23 with the Human Resources Director revealed: - Started with the [Licensee] approximately 3 weeks ago; - Had over 300 items(records and miscellaneous papers) to sort through; - Pulled personnel records and all the trainings on the requested staff for survey that was seen thus far.	V 536	Staff # 2 is scheduled to complete NCI+ training at UMAR's Central office on 4/11/23.	4/11/23
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly	V 736		

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V 736	Continued From page 23 manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observations and interviews the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observation on 2/2/23 at approximately 1:00pm of the facility revealed: - Bathroom #1 on left side of the hallway off from the kitchen had rust around the door and the door was difficult to close; - Bathroom #2 had brown and black stains around the tub; - Bathroom #2 had a hole beside the bath tub approximately 6 inches long and 2 inches wide; - Living room- beside the side door, around the vent and baseboards are black stains; - Client #4 bedroom floor is missing wood panel approximately 12 inches long and 3.5 inches wide. Interview on 3/9/23 with the Residential Manager revealed: - There was no one to complete maintenance request for about a year; - Just hired a person for maintenance; - The new maintenance staff will start completing maintenance request.	V 736	Work orders for bathrooms, Living rooms and client bedroom has been sent to the Property Operations Manager who is actively working to get items repaired so that the home is safe and in working order.	

UMAR
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April 5, 2023

NC Department of Health and Human Services
Attention: [redacted]
Mental Health Licensure & Certification Section

Dear [redacted]

Included is the Plan of Correction in response to the deficiencies identified during the annual, complaint, follow-up survey completed on March 9, 2023 at our Barnabas Group Home. Please review the Plan of Correction at your convenience and let me know if you have any question.

Best,

Sara Emser
Director of Quality Management and Compliance