Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-374	A. BUILDING: ______ B. WING ______	05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY BROTHERS HOUSE	3016 FORBES ROAD GASTONIA, NC 28056

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 05/10/2023. One complaint (intake #NC00196649) was unsubstantiated and one complaint (intake #NC00197829) was substantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 4 and currently has a census of 3. The survey sample consisted of audits of 2 current clients and 1 former client.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the	V 112	Mecca of Beacons takes fully responsibilty for being unable to provide updated PCP for client. The CFT was completed, however Gaston County DSS maintained the copy of the document, due to change of placement. Moving forward Mecca of Beacons AP will assure every client is scheduled for CFT monthly. Clincian will assure document is completed & stored in clients file. QP will assure each client has CFT meeting on calendar, attend each meeting & assure PCP is completed & filed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE ED, QP (X6) DATE 10/24/23

DHSR - Mental Health
MAY 31 2023
Lic. & Cert. Section

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V 112	Continued From page 1	V 112		

provider stating why such consent could not be obtained.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to develop and implement treatment strategies to address the needs of the client affecting 1 of 1 audited Former Clients (FC #3). The findings are:

Review on 05/10/2023 of FC #3's record revealed:
-14-years-old.
-Admitted 12/02/2022.
-Discharged 01/12/2023.
-Diagnoses of Attention Deficit Hyperactivity Disorder, Disruptive Mood Dysregulation Disorder, Generalized Anxiety Disorder, and Major Depressive Disorder.
-Comprehensive Clinical Assessment dated 11/14/2022 revealed: "... [FC #3] displays negative behaviors (cursing, physical aggression, verbal aggressions) when he cannot articulate his frustrations or if it is a situation that he misunderstands. [FC #3] continues to struggle to name other coping skills to help his frustrations when he is upset. He recently went AWOL (absent without leave) in 11/26/2022 for 15mins because he was upset with staff... [FC #3] symptoms of Disruptive mood dysregulation disorder are Exhibiting aggression 2 to 3 times

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V 112	Continued From page 2 per day during the week, impulsivity on decisions and tasks daily, irritability, screaming when mad 2 to 3 times a week, arguing a lot with adults, refusing to do what an adult asks, always questioning rules and refusing to follow rules, doing things to annoy or upset others, including adults, blaming others for the child's own misbehaviors or mistakes, being easily annoyed by others, often having an angry attitude, speaking harshly or unkindly when upset daily 1 to 3 times daily. Police were called due to [FC #3] assaulting a staff member on 10/29/2022. Staff member did sustain injuries from the assault." -No treatment strategies to address FC #3's difficulties with defiance, verbal and physical aggression, use of profanity, harm of others, difficulties with articulation of emotions, impulsivity, inability to take responsibility for his actions, and poor social interaction and understanding within 30 days of admission. Attempted Interview on 05/10/2023 with FC #3 was unsuccessful due to no response to phone call from his Department of Social Services (DSS) Guardian prior to survey exit date 5/10/2023. Interview on 05/10/2023 with the Executive Director/Licensee/Qualified Professional revealed: -Did not develop a treatment plan with strategies to address FC #3's needs. -"I think we did a CFT (Child and Family Team) meeting. I just cannot find the CFT meeting information."	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS	V 114	Mecca of Beacons will edit current document to show exact disaster drill completed. QP will assure staff will identify each drill.	

Division of Health Service Regulation

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V 114	Continued From page 3 AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure fire and disaster drills were conducted quarterly and repeated on each shift. The findings are: Review on 05/09/2023 of the facility's fire and disaster drills log from 09/01/2022- 04/30/2023 revealed: -No second shift (9 pm-9 am) fire and disaster drills for the third quarter July 2022 - September 2022 or the fourth quarter from October 2022 - December 2022. -No second shift (9 pm-9 am) fire and disaster drills for the first quarter January 2023 - March 2023. Interview on 05/09/2023 with Client #1 revealed: -Practiced fire and disaster drills. -Did not know where he should go if there was fire or disaster drill.	V 114	QP will also assure times will be reflected on each drill (AM/PM) QP will assure morning shift & night shift completes both drills. Mecca of Beacons has allocated location to go if fire and/or disaster as noted on plan. Dates + times will show when drills are completed, QP's role.	

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V 114	Continued From page 4 Interview on 05/09/2023 with Client #2 revealed: -Practiced fire and disaster drills. -"We go to the mailbox or the hallway and duck our heads." Interview on 05/10/2023 with Staff #1 revealed: -"I have done fire and disaster drills once." Interview on 05/10/2023 with Staff #2 revealed: -Completed fire drills once. -"It (fire and disaster drills) rotates, and staff is supposed to do it once every month I believe." Interview on 05/10/2023 with the Executive Director/Qualified Professional revealed: -Shifts were 9 am- 9 pm, 3 pm- 9 pm, and 9 pm- 9 am. -"We do two fire drills per month and two disaster drills per month." -Would ensure completion of fire and disaster drills on each shift and each quarter.	V 114	QP & AP will assure every staff member & every shift completes both drills monthly & quartery as state requires.	
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.	V 131	Mecca of Beacons will assure personal completes all background & trainings before offical start date. Both AP & QP will assure this is completed. Person will have both criminal & Health Care background completed prior to start date.	

Division of Health Service Regulation

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V 131	Continued From page 5 This Rule is not met as evidenced by: Based on records reviews and interviews, the facility failed to ensure the Health Care Personnel Registry (HCPR) was accessed prior to hire for 1 of 3 audited Staff (Executive Director (ED)/Qualified Professional (QP)). The findings are: Review on 05/10/2023 of the ED/QP's personnel record revealed: -Hire date 04/09/2022. -Job title ED/QP. -HCPR check 05/25/2022. Interview on 05/10/2023 with the ED/QP revealed: -Was responsible for completing HCPR checks. -"I should have used the other one (HCPR check from a prior employer)." -Would ensure HCPR checks were completed prior to conditional employment offer.	V 131	File showed updated background & HCPR. QP will assure old & updated background checks are in staff files.	
V 300	27G .1708 Residential Tx. Child/Adol - Trans or dischg 10A NCAC 27G .1708 TRANSFER OR DISCHARGE (a) The purpose of this Rule is to address the transfer or discharge of a child or adolescent from the facility. (b) A child or adolescent shall not be discharged or transferred from a facility, except in case of emergency, without the advance written notification of the treatment team, including the legally responsible person. For purposes of this Rule, treatment team means the same as the existing child and family team or other involved persons as set forth in Paragraph (c) of this Rule. (c) The facility shall meet with existing child and	V 300	Mecca of Beacons will assure all clients & clients treatment team plan & sign document for discharge date. QP will assure this is completed before every discharge. Gaston County & Mecca of Beacons were in agreement on discharge date, however facility was unable to provide during survey. All documentation (contracts & email) will be placed in clients file for documentation purposes	

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V 300	Continued From page 6 family teams or other involved persons including the parent(s) or legal guardian, area authority or county program representative(s) and other representatives involved in the care and treatment of the child or adolescent, including local Department of Social Services, Local Education Agency and criminal justice agency, to make service planning decisions prior to the transfer or discharge of the child or adolescent from the facility. (d) In case of an emergency, the facility shall notify the treatment team including the legally responsible person of the transfer or discharge of the child or adolescent as soon as the emergency situation is stabilized. (e) In case of an emergency, notification may be by telephone. A service planning meeting as set forth in Paragraph (c) of this Rule shall be held within five business days of an emergency transfer or discharge. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to coordinate service planning decisions prior to the transfer or discharge of the child or adolescent from the facility affecting 1 of 1 Former Clients (FC #3). The findings are. Review on 05/10/2023 of FC #3's record revealed: -14-years-old. -Admitted 12/02/2022. -Discharged 01/12/2023. -Comprehensive Clinical Assessment dated 11/14/2022 revealed: " ... [FC #3] displays negative behaviors (cursing, physical aggression,	V 300		

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V 300	Continued From page 7	V 300		

verbal aggressions) when he cannot articulate his frustrations or if it is a situation that he misunderstands. [FC #3] struggle to name other coping skills to help his frustrations when he is upset. He recently went AWOL (absent without leave) in 11/26/2022 for 15mins because he was upset with staff ...[FC #3] symptoms of Disruptive mood dysregulation disorder are Exhibiting aggression 2 to 3 times per day during the week, impulsivity on decisions and tasks daily, irritability, screaming when mad 2 to 3 times a week, arguing a lot with adults, refusing to do what an adult asks, always questioning rules and refusing to follow rules, doing things to annoy or upset others, including adults, blaming others for the child's own misbehaviors or mistakes, being easily annoyed by others, often having an angry attitude, speaking harshly or unkindly when upset daily 1 to 3 times daily. Police were called due to [FC #3] assaulting a staff member on 10/29/2022. Staff member did sustain injuries from the assault."
-No written 30-day discharge notice.
-No emergency CFT (Child and Family Tream) documentation to facilitate and coordinate FC #3's discharge.

Attempted Interview on 05/10/2023 with FC #3's Department of Social Services (DSS) Guardian was unsuccessful due to no response to phone call prior to survey exit date 5/10/2023.

Interview on 05/10/2023 with the Executive Director/Qualified Professional revealed:
-"They (FC #3 and DSS Guardian) went to medication management, and I said if the meds (medications) were not correct, we can't keep him..."
-"We told them (DSS), he had to go because the social worker was not consistent with getting his

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V 300	Continued From page 8 medications. He (FC #3) was discharged on 1/12/2023 because we met our contractual obligations." -Did not issue a written 30-day discharge notice for FC #3. -Did not assist the treatment team with locating alternative placement for FC #3.	V 300		
V 513	27E .0101 Client Rights - Least Restictive Alternative 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports that promote a safe and respectful environment. These include: (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include: (1) using the intervention as a last resort; and (2) employing the intervention by people trained in its use.	V 513	Mecca of Beacons takes fully responsibility for failing to comply w/ this incident. AP will begin to review all staff files monthly to assure all documents + trainings are updated. QP will maintain calendar for all training expiration dates + training schedules. QP will schedule trainings before expiration date for all clients + staff.	

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V 513	Continued From page 9	V 513		

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to use the least restrictive and most appropriate settings and method. The findings are:

Observation on 05/09/2023 at approximately 1:10 pm of the facility's pantry revealed:
-Pantry door locked.
-Staff #1 unlocked the door.
-Can goods, variety pack of potato chips, and other food items on the pantry shelves.

Interview on 05/09/2023 with Client #1 revealed:
-Snacks are stored in the pantry.
-Did not know if the pantry was locked.

Interview on 05/09/2023 with Client #2 revealed:
-Snacks are stored in the pantry.
-Did not know if the pantry was locked.

Interview on 05/10/2023 with Staff #1 revealed:
-"Staff are the only ones with keys to the pantry. Staff give clients snacks."

Interview on 05/10/2023 with Staff #2 revealed:
-"The pantry is always locked. Clients have to ask for snacks, and we get up and go get it."

Interview on 05/10/2023 with the Executive Director/Qualified Professional revealed:
-"The pantry should always be locked. If staff is interactive with the kids. It is only unlocked if there is no bleach in there."
-"Staff give clients snacks out of the pantry. I understand it is a client rights restriction."
-Would remove locks off the pantry door and relocate chemicals to another area.

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V 536	Continued From page 10	V 536		
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 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;	V 536	Mecca of Beacons AP will review all staff files monthly to assure all documents and trainings are updated. QP will maintain calendar for all training schedules. QP will schedule trainings before expiration dates for all staff.	

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V 536	Continued From page 11 (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 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	V 536		

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V 536	Continued From page 12	V 536		

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 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.

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MY BROTHERS HOUSE	3016 FORBES ROAD GASTONIA, NC 28056

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	Continued From page 13 (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 record review and interview, the facility failed to ensure refresher training alternatives to restrictive interventions was completed at least annually affecting 3 of 3 audited staff (#1, #2, and the Executive Director (ED)/Qualified Professional (QP)). The findings are: Review on 05/10/2023 of Staff #1's personnel record revealed: -Hire date 05/04/2022. -Initial Nonviolent Crisis Prevention & Intervention (CPI) Training in alternatives to restrictive interventions expired 4/30/2023. -No refresher CPI Training in alternatives to restrictive interventions. Review on 05/10/2023 of Staff #2's personnel record revealed:	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 536	Continued From page 14 -Hire date 05/03/2022. -Initial CPI Training in alternatives to restrictive interventions expired 4/30/2023. -No refresher CPI Training in alternatives to restrictive interventions. Review on 05/10/2023 of the ED/QP's personnel record revealed: -Hire date 04/09/2022. -Initial CPI Training in alternatives to restrictive interventions expired 4/30/2023. -No refresher CPI Training in alternatives to restrictive interventions. Interview on 05/10/2023 with Staff #1 revealed: -All trainings were up to date. -"I don't know how often we have to do the CPI training." Interview on 05/10/2023 with Staff #2 revealed: -All trainings were up to date. Interview on 05/10/2023 with the ED/QP revealed: -Was responsible for ensuring staff trainings were up to date. -Expired CPI Trainings were an oversight. -"I will get the trainings done ASAP (as soon as possible). It (CPI Trainings) will be done this week."	V 536		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have	V 537	AP will review all staff files monthly to assure all documents & trainings are updated. QP will maintain calendar for all training schedules. QP will schedule trainings before expiration date.	

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V 537	Continued From page 15 been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (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 plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others);	V 537		

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V 537	Continued From page 16	V 537		

(3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention);
(4) strategies for the safe implementation of restrictive interventions;
(5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention;
(6) prohibited procedures;
(7) debriefing strategies, including their importance and purpose; and
(8) documentation methods/procedures.
(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 Qualification 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 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out.
(3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.

Division of Health Service Regulation

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V 537	Continued From page 17 (4) 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. (5) 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 (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) 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	V 537		

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V 537	Continued From page 18 outcome (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. (l) 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. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 3 of 3 audited staff (#1, #2, and the Executive Director (ED)/Qualified Professional (QP)) completed refresher training in seclusion, physical restraint, and isolation time out. The findings are: Review on 05/10/2023 of Staff #1's personnel record revealed: -Hire date 05/04/2022. -Initial Nonviolent Crisis Prevention & Intervention (CPI) Training in seclusion, physical restraint, and isolation time out expired 4/30/2023. -No refresher CPI Training in seclusion, physical restraint, and isolation time out. Review on 05/10/2023 of Staff #2's personnel record revealed:	V 537		

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V 537	Continued From page 19	V 537		

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-No refresher CPI Training in seclusion, physical restraint, and isolation time out.

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Interview on 05/10/2023 with Staff #1 revealed:
-All trainings were up to date.
-"I don't know how often we have to do the CPI training."

Interview on 05/10/2023 with Staff #2 revealed:
-All trainings were up to date.

Interview on 05/10/2023 with the ED/QP revealed:
-Was responsible for ensuring staff trainings were up to date.
-Expired CPI Trainings were an oversight.
-"I will get the trainings done ASAP (as soon as possible). It (CPI Trainings) will be done this week."