STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411245	A. BUILDING: _____ B. WING _____	R 08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUCCESSFUL VISIONS-ROLLING ROAD	3600 ROLLING ROAD HIGH POINT, NC 27265

(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 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 8/23/23. The complaint was substantiated (intake # NC00204733). 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. This survey sample consisted of audits of 3 current clients and 1 former client.	V 000		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS 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 review and interview, the facility failed to ensure fire and disaster drills were held at least quarterly and repeated for each shift.	V 114		

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V 114	Continued From page 1 The findings are: Review on 8/17/23 of the facility's fire drill log from 2/11/23 - 8/5/23 revealed: - No fire drill was held on 2nd shift during the 1st quarter of 2023 (January - March) - No fire drill was held on 3rd shift during the 2nd quarter of 2023 (April - June) Review on 8/17/23 of the facility's disaster drill log from 2/18/23-7/20/23 revealed: - No disaster drills were held on 3rd shift during the 1st quarter of 2023 (January - March) - No disaster drills were held on 2nd or 3rd shift during the 2nd quarter of 2023 (April - June) Interview on 8/23/23 with the Qualified Professional and the Owner/Director revealed: - The facility had begun serving clients in February 2023 - Shifts were as follows: 1st shift (8 am - 4 pm); 2nd shift (4 pm - 12 am) and 3rd shift (12 am - 8 am) during the week - On weekends the shifts ran from 8 am - 8 pm and from 8 pm - 8 am - They felt certain the fire and disaster drills were done as required; however, staff had failed to use the correct forms (using the disaster drill form to document a fire drill) - The Owner/Director planned to redo the forms to make it easier for the staff to use the proper form	V 114		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall	V 118		

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V 118	Continued From page 2 only be administered to a client on the written order of a person authorized by law to prescribe 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 review and interview, the facility failed to ensure the quantity of the medications and instructions for administering the medications were listed on the client's MAR affecting 1 of 4 audited clients (#2). The findings are:	V 118		

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V 118	Continued From page 3	V 118		

Review on 8/16/23 of client #2's record revealed:
- An admission date of 6/9/23
- Diagnoses of Post Traumatic Stress Disorder (D/O), Unspecified by History; Attention Deficit Hyperactivity D/O, Unspecified by History; Mood Depressive D/O, Severe without Psychotic Features and Generalized Anxiety D/O

Review on 8/16/23 of the June 2023 MAR for client #2 revealed:
- The following medications and the times when the medications were to be administered: Vitamin D3 50 mcg (8 am); Geodon 20 mg (8 am); Geodon 80 mg (5 pm); Cetirizine 10 mg (8 pm); Lamotrigine 200 mg; (8 pm); Trazodone 50 mg (8 pm); Fish Oil 3000 mg (8 pm) and Prazosin 1 mg (8 pm)
- No evidence of instructions of how to administer the medications listed on the MAR

Interview on 8/23/23 with the Qualified Professional and the Owner/Director revealed:
- Acknowledgement client #2's June MAR did not have the instructions as to how the medications were to be administered; however, staff followed the instructions listed on the bubble pack" that contained the medications
- Each individual "bubble pack" contained all the medications to be administered at a specific time, (i.e., individual "bubble packs" held the number of pills/capsules client #2 was to receive at 8 am; 5 pm and 8 pm)
- Staff opened a specific "bubble pack" and administer all the medications held in that specific "bubble" to client #2
- The pharmacy sent over a July MAR with the medications and instructions listed when they began filling the client's prescriptions

If staff had any questions regarding how to administer the clients' medications, they knew to

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V 118	Continued From page 4 call either the QP or the Owner/Director with their concerns	V 118		
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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a check of the Health Care Personnel Registry (HCPR) was accessed prior to the date of hire for 1 of 5 audited staff (#1). The findings are: Review on 8/16/23 of staff #1's record revealed: - The date of hire was 6/15/23 - The HCPR was accessed on 6/16/23 Interview on with the Owner/Director revealed: - She was the one who accessed the HCPR on behalf of new employees - Acknowledgement the HCPR check was completed after staff #1's date of hire in this instance	V 131		

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V 366	Continued From page 5	V 366		
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 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	V 366		

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V 366	Continued From page 6 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 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	V 366		

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V 366	Continued From page 7 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. 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 II incidents affecting 1 of 3 current clients (#1) and 1 of 1 Former Clients (FC #4). The findings are: Review on 8/16/23 of client #1's record revealed: - An admission date of 2/14/23 - Diagnoses of Post-Traumatic Stress Disorder (D/O) and Mood Depressive D/O, Severe Review on 8/16/23 of FC #4's record revealed: - An admission date of 4/28/23 - Diagnoses of Oppositional Defiant D/O and Disruptive Mood Dysregulation D/O	V 366		

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V 366	Continued From page 8 - A discharge date of 7/26/23 Review on 8/16/23 of in-house incident reports completed by the Qualified Professional (QP) revealed: - On 6/14/23, the QP called the police to report client #1 and FC #4's left the facility without staff permission and could not be located by staff - On 7/19/23, the QP called the police to report FC #4 failed to return to the facility after the school day ended - On 7/26/23, the QP called the police to report FC #4 left the facility without staff permission and could not be located by staff Review on 8/15/23 and 8/16/23 of the Incident Response Improvement System (IRIS) revealed: - No evidence of any incident reports regarding the phone calls made by the QP to the police on 6/14/23; 7/19/23 and 7/26/23 - No documentation of facility having provided a response to the Local Management Entity/Managed Care Organization (LME/MCO) via IRIS of how the facility had determined the cause of the elopements by client #1 and FC #4; what corrective measures the provider would develop and implement regarding these incidents; what measures the facility would develop and implement to prevent similar incidents and the assigned person(s)responsible for the implementation of the corrections and preventative actions Interview on 8/17/23 with the QP revealed: - She had submitted an incident report about FC#4's elopement from the facility on 7/19/23 to IRIS as required and received an incident number for the report - Believed that since she had received an incident number the report had been submitted	V 366		

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V 366	Continued From page 9 successfully to the system - Had completed only internal incident reports regarding the incident on 6/14/23 and on 7/26/23 Review on 8/17/23 of a copy of the incident report the QP submitted to IRIS regarding FC #4 and the events of 7/19/23 revealed: - A page of the incident report which reflected an incident number; however, the date listed on the report was 1/1/0001 which was an indication the report was not accepted by IRIS	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 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	V 367		

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V 367	Continued From page 10 (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 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:	V 367		

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V 367	Continued From page 11 (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 review and interview, the facility failed to report all level II incidents to the Local Management Entity (LME) responsible for the catchment area were services were provided within 72 hours of becoming aware of the incident affecting 1 of 1 current client (#1) and 1 of 1 former clients (#4). The findings are: Review on 8/16/23 of client #1's record revealed: - An admission date of 2/14/23 - Diagnoses of Post-Traumatic Stress Disorder (D/O) and Mood Depressive D/O, Severe Review on 8/16/23 of FC #4's record revealed: - An admission date of 4/28/23 - Diagnoses of Oppositional Defiant D/O and	V 367		

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V 367	Continued From page 12 Disruptive Mood Dysregulation D/O - A discharge date of 7/26/23 Review on 8/17/23 of in-house incident reports completed by the Qualified Professional (QP) revealed: - On 6/14/23, client #1 and FC #4 left the facility without staff permission some time after 9 pm - Staff called the police after learning the clients (#1 and FC #4) were not in their bedrooms and again when they returned to the facility the between 3:30 and 4 am the morning of 6/15/23 to "assist for (the clients') safety and wellbeing." - On 7/19/23, the QP called the police after FC #4 failed to return to the facility after school ended - On 7/26/23, the QP called the police after FC#4 left the facility (no time provided) without staff permission Interview on 8/17/23 with the QP revealed: - She had submitted an incident report about FC#4's elopement from the facility on 7/19/23 to the Incident Response Improvement System (IRIS) as required and had been given an incident number - She had completed only internal incident reports regarding the incident on 6/14/23 and on 7/26/23 Review on 8/17/23 of IRIS revealed: - No evidence of any incident report concerning the telephone call to the police on 7/19/23 to report FC #4's failure to return to the facility after school Review on 8/17/23 of a copy of the incident report she submitted to IRIS regarding FC #4 and the events of 7/19/23 revealed:	V 367		

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V 367	Continued From page 13 - A page of the incident report which reflected an incident number; however, the date listed on the report was 1/1/0001 which was an indication the report was not accepted by the system	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 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	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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUCCESSFUL VISIONS-ROLLING ROAD	3600 ROLLING ROAD HIGH POINT, NC 27265

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V 536	Continued From page 14 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 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:	V 536		

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V 536	Continued From page 15 (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 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.	V 536		

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V 536	Continued From page 16 (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 record review and interview, the facility failed to ensure 2 of 5 audited staff (#1 and #2) received initial training on alternatives to restrictive interventions prior to providing services to people with disabilities. The findings are: Review on 8/16/23 of staff #1's record revealed: - The date of hire was 6/6/23 - Staff #1 completed initial training on alternatives to restrictive interventions on 8/11/23 Review on 8/16/23 of staff #2's record revealed: - The date of hire was 5/31/23	V 536		

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V 536	Continued From page 17 - Staff #1 completed initial training on alternatives to restrictive interventions on 8/11/23 Interview on 8/23/23 with the Owner/Director revealed: - It was more expensive to send just staff (#1 and #2) to a class in alternatives to restrictive interventions with only the two on them in attendance - She waited until the trainer offered a class in August 2023 in which staff #1 and #2 would not be the only participants and thus the training would be less expensive	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 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	V 537		

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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);
(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

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V 537	Continued From page 19	V 537		

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.
(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

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V 537	Continued From page 20 (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 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.	V 537		

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This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure 2 of 5 audited staff (#1 and #2) received initial training in seclusion, physical restraint and isolation time-out prior to providing services to people with disabilities. The findings are:

Review on 8/16/23 of staff #1's record revealed:
- The date of hire was 6/6/23
- Staff #1 completed initial training in seclusion, physical restraint and isolation time-out on 8/11/23

Review on 8/16/23 of staff #2's record revealed:
- The date of hire was 5/31/23
- Staff #1 completed initial training in seclusion, physical restraint and isolation time-out on 8/11/23

Interview on 8/23/23 with the Owner/Director revealed:
- It was more expensive to send just staff (#1 and #2) to a class in seclusion, physical restraint and isolation time-out with only the two of them in attendance
- She waited until the trainer offered a class in August 2023 in which staff #1 and #2 would not be the only participants and thus the training would be less expensive