STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-362	A. BUILDING: ______ B. WING ______	12/22/2023

NAME OF PROVIDER OR SUPPLIER: **SPRINGWELL NETWORK, INC-BRANDYWINE I**

STREET ADDRESS, CITY, STATE, ZIP CODE: **2588 BRANDYWINE RD, WINSTON-SALEM, NC 27103**

(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 survey was completed on 12/22/23. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with a Developmental Disability. This facility is licensed for 6 and currently has a census of 4. The survey sample consisted of audits of 2 current clients and 1 former client.	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall	V 110	According to 27G.0204 Competencies Supervision of Paraprofessionals the staff was trained on all requirements however the agency failed to ensure that the staff was confident about the process for full implementation. The agency does have the responsibility to support all employees and we have developed a new training contract and process to support the confidence level of all employees. All employees should demonstrate the knowledge, skills, and abilities required by the populatiion served. All employees will receive an updated copy of the training contract and information on the training process. The updated process will be implemented 01/14/2024 with new staff and existing staff will be updated at the agency wide meeting. The meeting is scheduled for Jan 7 at 10am Responsible Staff: [redacted] Executive Director [redacted]ations Director Qualified Professional RECEIVED FEB 6 2024 DHSR-MH Licensure Sect	Completion 01/29/2024 (New Staff) Pending 02/07/24 for existing employees

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charlene Warren (signed) Charlene Warren ED.

TITLE: Executive Director

(X6) DATE: 02/02/2024

Division of Health Service Regulation

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V 110	Continued From page 1 develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 4 audited staff (staff #1) demonstrated the knowledge, skills and abilities required by the population served. The findings are: Cross Reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112). Based on record review and interview, the facility failed to implement strategies listed in the client's treatment/habilitation plan affecting 1 of 1 Former Client (FC #1). Review on 12/14/23 of Former Client #1's (FC #1's) record revealed: - An admission date of 11/1/15 - A discharge date of 11/10/23 - Diagnoses of Intellectual Developmental Disability, Moderate; Myotonic Muscular Dystrophy; Esophageal Motor Disorder; Menorrhagia; Dysphagia and Epiretinal Membrane of Both Eyes - Client was 42 years of age - A treatment plan dated 7/1/23 completed by the facility's QP revealed "...[FC #1] continues to be at risk for falls and injuries due to the degenerative nature of her myotonic Muscular Dystrophy..."and when she was mobile (using her	V 110	According to rule 10A NCAC 27G 0205 the facility failed to implement strategies listed in the client's treatment/habilitation plan. The agency has changed the orientation process for new employees to support the requirements of employment Each new hire will be documented for orientation training that will be be conducted within the first 30 days of employment for client interaction. The training will be conducted by the Supervisor and the QP will review the process with new staff during the site review. Orientation information will be stored in personel file and the site visit will be stored with the Operations Director. Staff will receive review when the plan of supervision is conducted. Each employee will receive a copy of client specfics and discussion for each client will take place upon hire and when updates take place. All clients who are high risk will have a review by QP on a monthly basis at during site Employees will recieve information on updated process at the agency wide meeting which will be held 02/07/2024. Responsible Staff: [redacted] Executive Director [redacted]ations Director Qualified Professional	Completion 01/29/2024 (New Staff) Pending 02/07/2024 Existing Employees

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NAME OF PROVIDER OR SUPPLIER: SPRINGWELL NETWORK, INC-BRANDYWINE I

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V 110	Continued From page 2	V 110		

walker), the staff working with her should remain at "arm's reach when possible..."
- The treatment plan also reflected that if the staff working with FC #1 needed to step away from her, that staff should request other staff to monitor FC #1 until they returned
- A client specific form completed by the facility's QP and dated 7/1/23 revealed the following "...Medical Issues/Concerns: Consumer has myotonic muscular dystrophy and dysphagia. She uses a wheelchair for mobility when out of the group home and a walker or wheelchair in the group home....She needs to be monitored when mobile for safety as she can trip and fall..."

Review on 12/14/23 of staff #1's record revealed:
- A hire date of 10/10/23 as a Paraprofessional
- A "client specific form" for FC #1 signed and dated 10/10/23 by staff #1
- The "client specific" form listed FC #1's "diagnoses; social functioning; daily routine; communication techniques; likes/dislikes; behavioral concerns; medical issues and concerns and medications" as well as others involved in her care
- The "client specific form" specifically listed the FC #1's need for staff supervision at all times whenever she was mobile to ensure her safety
- A statement on the client specific form listed above the staff #1's signature revealed "...Signatures below verify that training in the elements indicated above has been completed and the staff person understands his/her responsibilities relating to the named consumer. Update information as changes occur and ensure signature by all employees working at location..."
- This same form was also signed and dated 10/10/23 by the Operations Manager

Interview on 12/22/23 with the Operations

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V 110	Continued From page 3 Manager revealed: - She had reviewed FC #1's needs with staff #1 on 10/10/23 which was prior to her beginning to work with FC #1 in the facility - Staff #1 was well aware of what FC #1's needs were, including her need for supervision when she was mobile in order to ensure her safety Review on 12/22/23 of the Plan of Protection dated 12/22/23 and written by the Operations Manager revealed: - "What immediate action will the facility take to ensure the safety of the consumers in your care? A one-hour presentation for staff teams focusing on Assessment of Fall Risk and Prevention of Falls, incorporating the organization policy and procedure will be provided to all employees of Brandywine Group Home Springwell Network, Inc. The training will be conducted by [Regional Health Education Center] or another registered professional. Outcomes: Staff at Springwell Network attending this presentation will receive evidence-based information related to Fall Risk Assessment/Become familiar with concepts vital to Fall Prevention/Have the tools needed to create a safe environment of care through heightened awareness of potential fall hazards. Objectives: Summarize steps to take to prevent falls and promote safety for residents/Recognize policy and procedures in place at the facility regarding fall risk and prevention/Demonstrate a proactive approach to identify and fix all fall hazards. Outline: What is a fall? Why do falls happen?/Assessing fall risk: Low, Moderate and High/What personal care team staff must do if a client falls/Collaborative approach to care planning/Precautions and Interactions - be alert and build a culture of safety. Plan:/A one-hour live	V 110		

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V 110	Continued From page 4 [via video conferencing software] presentation for staff teams focusing on Assessment of Fall Risk and Prevention of Falls incorporating content as noted above will be provided. To accommodate shifts of teams, one presentation at 10 AM and one at 6 PM. Faculty of [Regional Health Education Center]. - Describe your plans to make sure the above happens. The current falls policy for appropriate assessment will be reviewed with staff on an annual basis. Employee orientation checklist will be completed for all new employees. Each employee will receive a copy of the agency's falls policy and Supervisors and Qualified Professionals will discuss any incidents that involve falls at staff meetings and will allow ample time for questions. Copy of the minutes will be stored in the electronic system [electronic documentation system]. The agency will examine yearly employee competency to ensure that falls are included in the training curriculum. Review with new staff Treatment Plans ISP (Individual Support Plan) or PCP (Person Centered Plan) to ensure competency skills. Review Client Specifics and Shadow prior to job responsibilities if providing service. Shadow staff prior to staff working in the facility." The facility served Former Client #1 (FC #1) from 11/1/15 until her discharge from their care on 11/10/23. FC #1 had diagnoses of Intellectual Developmental Disability, Moderate; Myotonic Muscular Dystrophy; Esophageal Motor Disorder; Menorrhagia; Dysphagia and Epiretinal Membrane of Both Eyes. FC #1 required the use of a wheelchair, a walker, and an adapted foot orthotic to assist in her mobility. FC #1 had a history of tripping and falling and had been designated as a fall risk. On 10/16/23, when staff #1 had been assigned to work specifically with FC	V 110		

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V 110	Continued From page 5 #1, she left her unattended in the bathroom and FC #1 fell to the bathroom floor. Staff #1 failed to follow the strategies listed in FC #1's treatment plan which required staff to monitor FC #1 whenever she was mobile and to request assistance from other staff prior to leaving FC #1 alone. On 10/17/23, FC #1 was taken by staff to an urgent care center where it was determined she had a broken tibia which would require surgical repair. This deficiency constitutes a Type A1 rule violation for serious harm and must be corrected within 23 days. An administrative penalty of $1000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 110		
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	V 112		

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V 112	Continued From page 6 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 provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement the goals and strategies listed in the treatment/habilitation plan to address the client's needs affecting 1 of 1 Former Client (FC #1). The findings are: Review on 12/14/23 of Former Client #1's (FC #1's) record revealed: - An admission date of 11/1/15 - A discharge date of 11/10/23 - Diagnoses of Intellectual Developmental Disability, Moderate; Myotonic Muscular Dystrophy; Esophageal Motor Disorder; Menorrhagia; Dysphagia and Epiretinal Membrane of Both Eyes - Client was 42 years of age - An admission assessment dated 2/9/10 which revealed " ...has physical limitations and has difficulty with balance, strength in her hands ..." - A client specific form completed by the facility's Qualified Professional (QP) and dated	V 112	According to rule 10A NCAC 27G 0205 the facility failed to implement strategies listed in the client's treatment/habilitation plan to address the client's needs. The agency has changed the orientation process for new employees to support the requirements of employment new employee will be documented for orientation training that will be be conducted within the first 30 days of employment for client interaction. The training will be conducted by the Supervisor and the QP will review the process with new staff during the site review. Orientation information will be stored in personel file and the site visit will be stored with the Operations Director. Staff will receive review when the plan of supervision is conducted. Each employee will receive a copy of client specfics and discussion for each client will take place upon hire and when updates take place. All clients who are high risk will have a review by QP on a monthly basis at during site Employees will recieve information on updated process at the agency wide meeting which will be held 02/07/2024.	Completion 01/29/2024 (New Staff) Pending 02/07/2024 Existing Employees

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V 112	Continued From page 7 7/1/23 which reflected the following "...Medical Issues/Concerns: Consumer has myotonic muscular dystrophy and dysphagia. She uses a wheelchair for mobility when out of the group home and a walker or wheelchair in the group home. She propels herself in her wheelchair. She needs to be monitored when mobile for safety as she can trip and fall accidentally or slide out of her wheelchair for attention. She has poor depth perception and does not walk over uneven surfaces...." - "...She has safety guidelines for eating, mobility, and transfers. She wears a helmet, gait belt, and right AFO (Adapted Foot Orthotic) ..." - A treatment plan dated 7/1/23 and completed by the facility's QP revealed: "...1) [FC #1] will maintain her safety and appropriate use of her physician ordered devices with no more than 2VPs (Verbal Prompts) for 6 consecutive months ..." - "...[FC #1] continues to be at risk for falls and injuries due to the degenerative nature of her myotonic Muscular Dystrophy..." - The treatment plan reflected that when FC #1 was mobile, she should be monitored by the staff working with her to remain at "arm's reach when possible." - If staff working with FC #1 needed to step away from FC #1, that staff should request other staff to monitor FC #1 until they could return Review on 12/14/23 of the North Carolina Incident Response Improvement System (IRIS) revealed: - An incident report last submitted on 10/18/23 to IRIS by the Operations Manager revealed on 10/16/23 at 7 pm, FC #1 fell while she was in the bathroom preparing for her evening shower - Staff #1 called for staff #2 to come to the bathroom to assist her in getting FC #1 up from the floor	V 112		

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- Staff (#1 and #2) checked FC #1 for any injuries; with staff noting they observed only a "bruise" on FC #1's shoulder and "scrapes on right knee."
- The morning of 10/17/23, FC #1 complained of leg pain and the Group Home Supervisor (GHS) completed a check of FC #1's body and observed there to be swelling in FC #1's left leg
- The GHS transported FC #1 to a "medical center" where x-rays were completed and it was determined that FC #1's "tibia was broken."
- Urgent care personnel recommended FC #1 be transferred to a hospital via ambulance for further treatment
- FC #1 was admitted to the hospital on 10/17/23 and surgery on her leg was scheduled for 2 pm on 10/18/23

Interview on 12/18/23 with staff #1 revealed:
- On 10/16/23, she was walking with FC #1 into the bathroom
- FC #1 was using her walker at the time she was going into the bathroom
- As she and FC #1 entered the bathroom, client #2 "went running past her."
- She thought client #2 had "something in his hand" so she called out to staff #2 to check on client #2
- She left FC #1 alone in the bathroom when she stepped into the hallway to call staff #2
- She remained in the hallway until after staff #2 ran past her
- When staff #2 came past her while she was in the hallway, staff #2 pushed the bathroom door shut, leaving FC #1 inside the bathroom alone
- Believed that when staff #2 pushed the bathroom door shut, it may have struck FC #1, which caused her to fall
- She immediately opened the door and

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V 112	Continued From page 9	V 112		

observed FC #1 sitting on the bathroom floor
- Staff #2 assisted her in getting FC #1 up from the floor and she and staff #2 checked her for any injuries
- "It happened so fast ...I can't explain it ...that was crazy that day."
- "He came so fast; I hadn't even turned on the light in the bathroom."
- She realized that FC #1 should not have been left in the bathroom alone
- "It was so fast, I don't know ...it was so crazy and fast."

Review on 12/14/23 of staff #2's record revealed:
- A hire date of 4/23/18 as a Paraprofessional

Interview on 12/18/23 with staff #2 revealed:
- On 10/16/23, staff #1 was to work specifically with FC #1
- FC #1 always had a worker to work with her individually; however, if that staff needed assistance, he would help if he were on shift
- He was in the facility's office completing documentation, when he heard staff #1 call out to him for help
- When he came out of the office, he observed staff #1 standing in the hallway by the bathroom
- Staff #1 reported to him that she believed client #2 had something he wasn't allowed to have and wanted him to check on client #2
- When he walked past staff #1, he noticed the bathroom door was shut; however, he did not know how the door came to be closed
- Overheard FC #1 say "OWW!" and when he and staff #1 opened the bathroom door, they observed FC #1 on the bathroom floor
- He also observed FC #1's walker in the bathroom with her
- Helped FC #1 get up from the floor and after checking her, he did not observe any significant

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V 112	Continued From page 10	V 112		

injuries on her, other than bruises on her left shoulder and on one of her knees
- On 10/17/23, FC #1 reported her leg was hurting and the GHS took her to an urgent care for an evaluation
- Was not sure why or how FC #1 ended up on the floor, however; "[Staff #1] should have never left [FC #1] alone in the bathroom."

Interview on 12/16/23 with the QP revealed:
- In reviewing what happened on 10/16/23, staff #1 reported she was assisting FC #1 as she was preparing for her shower; but "something about [client #2's] behavior distracted her."
- Staff #1 left FC #1 unattended when she should have remained in the bathroom with FC #1
- When staff #1 returned to the bathroom, she observed FC #1 on the bathroom floor
- Staff #1 called for staff #2's assistance in checking on client #2 and in getting FC #1 up from the floor of the bathroom
- Staff #2 also assisted staff #1 with checking FC #1 for any possible injuries from her fall
- Staff (#1 and #2) reported the only injuries to FC #1 were "scrapes to her knee."
- The following day the GHS took FC #1 to the urgent care center when FC #1 complained of leg pain
- FC #1 was sent to the emergency department of a local hospital for additional medical treatment
- On 10/18/23, surgery was performed on FC #1's leg due to her having a broken tibia

Interview on 12/22/23 with the GHS revealed:
- On 10/16/23, FC #1 fell while she was left alone in the bathroom by staff #1
- FC #1 should not have been left alone in the

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V 112	Continued From page 11 bathroom due to her mobility issues - Staff #1 had been trained to work specifically with FC #1 and should have understood what was required of her when she worked with FC #1 Interview on 12/22/23 with the Operations Manager revealed: - Staff #1 worked at the day program FC #1 attended and had also been hired to work in the facility where FC #1 resided - On 10/16/23, FC #1 was on shift from 3 pm until 6 pm to work specifically with FC #1 - As the Operations Manager, she had reviewed FC #1's needs with staff #1 prior to her beginning work at the facility with FC #1 - Staff #1 "was well aware" of what FC #1's needs were, including her need for supervision/monitoring when she was mobile This deficiency is cross referenced into 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110) for a Type A1 for serious harm.	V 112		Completion 01/29/2024 (New Staff) Pending 02/07/24 for existing employees
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		

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	MHL034-362	A. BUILDING: ______ B. WING ______	12/22/2023

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V 131	Continued From page 12 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Health Care Personnel Registry (HCPR) was accessed prior to the date of hire for 1 of 4 audited staff (the Group Home Supervisor) (GHS). The findings are: Review on 12/14/23 of the Group Home Supervisor's (GHS's) record revealed: - A hire date of 10/10/23 - The HCPR was accessed on behalf of the GHS on 11/7/23 Interview on 12/22/23 with the Operations Manager revealed: - Acknowledgement the HCPR should be accessed prior to the date of hire for prospective employees	V 131	Based on the employment standard for employment G.S. 131E-256 (D2)-HCPR-Prior Employment Verification, the facilty failed to verify information prior to hire. This process must be implemented as required. The agency will have the administrative assistant and Operations Director will go through all files to ensure the document is in place for all. The employee handbook and Policy and Procedures will be updated. The agency has changed the process of hiring: New orientation checklist New assignments for Operation Director New assignments for Administrative Assistant New assignments for Qualified Professional New assignments for Supervisor Staff Responsible: [redacted] Executive Director [redacted] rations Director Administrative Assistant Qualified Professional	Completion 01/29/2024 (New Staff) Pending 02/07/24 for existing employees
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.	V 536		

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V 536	Continued From page 13 (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; (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	V 536		

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V 536	Continued From page 14	V 536		

(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 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

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V 536	Continued From page 15 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. (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.	V 536		

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V 536	Continued From page 16 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff received initial training in training on alternatives to restrictive interventions prior to providing services to persons with disabilities for 1 of 4 audited staff (the Group Home Supervisor) (GHS). The findings are: Review on 12/14/23 of the Group Home Supervisor's (GHS's) record revealed: - A hire date of 10/10/23 - The GHS received training in alternatives to restrictive interventions on 11/10/23 Interview on 12/22/23 with the Operations Manager revealed: - Confirmation the GHS did not receive the training until 11/10/23 as she was the individual who provided the GHS with the training	V 536	According to the standard 27E.0107, Training on Alternatives to Restrictive Interventions the agency will implement a new hiring process to ensure all trainings are completed as required. New staff will go through the new hiring process to ensure compliance and monitoring to meet all standards. Responsibilies have been assigned and each trainer has forms to complete before final hire date is established. All existing employees will go through a recertification process. The Administrative Assistant and Operations Director will not set a hire date for any employee until required trainings are verified. Policy in employee handbook and policy and procedures will be updated. Responsible Staff [redacted] Executive Director [redacted] rations Director Administrative Assistant Qualfied Professional	Completion 01/29/2024 (New Staff) Pending 02/07/24 for existing employees