STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. l'	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED				
				A. BUILDING.			₹			
		MHL092-917	E	B. WING			2/2024			
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE									
LEARNII	NG SERVICES CORP	ORATION-WILLO\		NG FUTUR NC 27610	ES CIRCLE					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE			
V 000	INITIAL COMMEN	тѕ		V 000						
	An annual and follow up survey was completed on 5/22/24. Deficiencies were cited.									
	This facility is licensed for the following service category: 10A NCAC 27G .2100 Specialized Community Residential Centers for Individuals with Developmental Disabilities.									
		sed for 12 and has a curre urvey sample consisted of clients.								
V 118	27G .0209 (C) Med	lication Requirements		V 118						
	V 118 27G .0209 (C) Medication Requirements  10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe 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									

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` ′	E CONSTRUCTION	(X3) DATE COMI	SURVEY PLETED
				7. BOILDING.			R
		MHL092-917		B. WING			22/2024
NAME OF	PROVIDER OR SUPPLIER	ST	REET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LEARNII	NG SERVICES CORP	ORATION-WILLOL		OING FUTUR , NC 27610	ES CIRCLE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
V 118	drug. (5) Client requests checks shall be red file followed up by with a physician.  This Rule is not make a passed on record red interviews the facili medications on the	et as evidenced by: eviews, observations, and ty failed to administer e written order of a physic its (#1 and #2). The find	MAR tion d	V 118	DEI IOLEIGI)		
	revealed: - admitted 9/26/2 - diagnosis: Trau - review of physirevealed: - Duloxetine 60n (BID) (diabetic peri - Fish oil 1000m - Furosemide 20 - Gabapentin 30 12pm & 4pm (seizu - Melatonin 3mg - Metformin 500 - Methenamine - Oxybutynin 5md - Vitamin C 500n - Vitamin D3 100	umatic Brain Injury (TBI) ician's orders dated 5/15 mg (milligram) twice a data pheral) g 2 BID (inflammation) mg bedtime (fluid retent 0mg 3 at 8am & 8pm, 2 ure) 2 bedtime (sleep) mg BID (diabetes) 1 gram BID (ADHD) mg everyday (bladder) mg BID 00mg everyday  of client #1's March 24,	i/24 iy tion) at				

Division of Health Service Regulation

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		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:	
MHL092-917			R <b>05/22/2024</b>
	l .		05/22/2024
	TREET ADDRESS, CITY, S <b>70 BUILDING FUTUR</b>		
I FARNING SERVICES CORPORATION-WILLO	ALEIGH, NC 27610	RES CIRCLE	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FU TAG REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE COMPLETE
V 118 Continued From page 2	V 118		
V 118 Continued From page 2  - no documentation of medication administration for the entire month of Marc April for the following:  - Duloxetine - Fish oil - Furosemide - Metformin - Oxybutynin - Gabapentin: missing staff initials from 3/31/24 - no documentation of medication administration from 5/1/24 - 5/14/24 for the following medications - Duloxetine - Fish oil - Furosemide - Gabapentin - Melatonin - Metformin - Methenamine - Oxybutynin - Vitamin C - Vitamin D - bottom of the MAR were the following questions: - did client initiate medication pass? indives or no - did client take all medications? indication - staff initials were documented beside yoo, however the medications were not listed.  B. Review on 5/15/24 of client #2's record revealed: - admitted 7/12/23 - diagnosis: Traumatic Brain Injury (TBI) - review of physician's orders dated 3/16 revealed: - Amantadine 100 milligrams (uncontroled)	icate e yes or yes or ed		

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NAME OF PROVIDER OR SUPPLIER  LEARNING SERVICES CORPORATION-WILLO\  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIES  B. WING  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  570 BUILDING FUTURES CIRCLE  RALEIGH, NC 27610  [X5]  PROVIDER'S PLAN OF CORRECTION (X5)	STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER  LEARNING SERVICES CORPORATION-WILLON  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 118  Continued From page 3  - Atorvastatin 40mg (high cholesterol) nightly - Levetiracetam 1000 mg (seizures) daily - Melatonin 3 mg (sleep) at bedtime - self administration orders for medication - discontinue order for Amantadine 100 mg twice daily on 4/6/24 - physician's order on 4/6/24 for Levetiracetam 1250 mg twice daily at 8:00am and 8:00pm  Review on 5/15/24 of client #2's March 24, April 24, and May 24 MARs revealed the following:				,			₹
CX4) ID   SUMMARY STATEMENT OF DEFICIENCIES   EACH DEFICIENCY MUST BE PRECEDED BY FULL   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX   TAG   TAG   CROSS-REFERENCED TO THE APPROPRIATE   DATE			MHL092-917	B. WING		1	
CX4) ID   SUMMARY STATEMENT OF DEFICIENCIES   CEACH DEFICIENCY MUST BE PRECEDED BY FULL   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   TAG   COntinued From page 3   Continued From page 3   V 118   Continued From page 3   Atorvastatin 40mg (high cholesterol) nightly   Levetiracetam 1000 mg (seizures) daily   Melatonin 3 mg (sleep) at bedtime   self administration orders for medication   discontinue order for Amantadine 100 mg twice daily on 4/6/24   physician's order on 4/6/24 for Amantadine 100 mg twice daily on 4/6/24   physician's order on 4/6/24 for Levetiracetam 1250 mg twice daily at 8:00am and 8:00pm   Review on 5/15/24 of client #2's March 24, April 24, and May 24 MARs revealed the following:	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 118  Continued From page 3  - Atorvastatin 40mg (high cholesterol) nightly - Levetiracetam 1000 mg (seizures) daily - Melatonin 3 mg (sleep) at bedtime - self administration orders for medication - discontinue order for Amantadine 100 mg twice daily on 4/6/24 - physician's order on 4/6/24 for Amantadine 100 mg once daily - discontinue order for Levetiracetam 1000 mg twice daily on 4/6/24 - physician's order on 4/6/24 for Levetiracetam 1250 mg twice daily at 8:00am and 8:00pm  Review on 5/15/24 of client #2's March 24, April 24, and May 24 MARs revealed the following:	LEARNII	NG SERVICES CORPO	ORATION-WILLOV		RES CIRCLE		
- Atorvastatin 40mg (high cholesterol) nightly - Levetiracetam 1000 mg (seizures) daily - Melatonin 3 mg (sleep) at bedtime - self administration orders for medication - discontinue order for Amantadine 100 mg twice daily on 4/6/24 - physician's order on 4/6/24 for Amantadine 100 mg once daily - discontinue order for Levetiracetam 1000 mg twice daily on 4/6/24 - physician's order on 4/6/24 for Levetiracetam 1250 mg twice daily at 8:00am and 8:00pm  Review on 5/15/24 of client #2's March 24, April 24, and May 24 MARs revealed the following:	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	_D BE	COMPLETE
administration for the entire month of March and April for:  - Amantadine - Atorvastatin - Levetiracetam - Melatonin - a 12pm dose of Levetiracetam added to MAR on 4/7/24 and 4/8/24 with no staff initials - Amantadine 100mg twice daily had "D/C" written on April MAR dated 4/6/24 - Amantadine 100mg once daily added to April MAR 4/10/24 - no documentation of medication administration from 5/1/24-5/14/24 for the following: - Amantadine - Atorvastatin - Levetiracetam - Melatonin - no staff initials documented beside yes or no from 4/10/24-4/16/24  During interview on 5/2/2/24 client #2 reported:	V 118	- Atorvastatin 40 - Levetiracetam - Melatonin 3 mg - self administrat - discontinue ord twice daily on 4/6/2 - physician's ord 100 mg once daily - discontinue ord twice daily on 4/6/2 - physician's ord 1250 mg twice daily Review on 5/15/24 24, and May 24 MA - no documentat administration for tl April for: - Amantadin - Atorvastati - Levetiracet - Melatonin - a 12pm dose o on 4/7/24 and 4/8/2 - Amantadine 10 written on April MAI - Amantadine 10 MAR 4/10/24 - no documentat administration from following: - Amantadin - Atorvastati - Levetiracet - Melatonin - no staff initials from 4/10/24-4/16/2	mg (high cholesterol) nightly 1000 mg (seizures) daily g (sleep) at bedtime tion orders for medication der for Amantadine 100 mg 4 er on 4/6/24 for Amantadine der on 4/6/24 for Levetiracetam y at 8:00am and 8:00pm of client #2's March 24, April ARs revealed the following: ion of medication he entire month of March and entire month of March and following twice daily had "D/C" R dated 4/6/24 for month of medication had a few themselves a few that a	V 118			

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Division	of Health Service Re	egulation						
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLI	ER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NU		A. BUILDING:		COMP	LETED	
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						F		
		MHL092-917		B. WING		05/2	2/2024	
			070557.40	DDEGG GITV	7175 710 00D5			
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE			
IEADNIN	NG SERVICES CORPO	OPATION_WILLO	570 BUIL	DING FUTUR	RES CIRCLE			
LLAKKII	10 OLIVIOLO COIVI V	JIAHON-WILLON	RALEIGH	, NC 27610				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECT	ON	(X5)	
PREFIX		/ MUST BE PRECEDED BY		PREFIX	(EACH CORRECTIVE ACTION SHOU		COMPLETE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORM	ATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE	
					DEFICIENCY)			
V/ 44 0	O	4		V/ 44.0				
V 118	Continued From pa	ige 4		V 118				
	- "You have days	assigned where yo	u nack					
	medication."	assigned where yo	и раск					
		ually through your m	adiaatian					
		ually through your m						
		ncy and time of day						
		little pill box and that	gets					
	locked up in the me							
		en it's your time to ge	et					
	medicine."							
	- "They give you the whole pill planner and							
	monitor you as you	do it."						
	- "Half the time t	hey put it in a cup. H	alf the					
		nt out of the planner						
		atching the whole thi						
	But otall to there we	atorning and minore an						
	During interview on	5/15/24 nurse #1 re	norted:					
		cility on 3/15/24	portou.					
		not have a 12pm dos	se oi					
	Levetiracetam							
		Levetiracetam to the						
		l 4/8/24 was an erro						
		ntadine order chang	ed on					
	4/6/24 from twice d							
	<ul> <li>was not sure w</li> </ul>	hy Amantadine once	daily was					
	not listed on April M	1AR until 4/10/24						
	- unsure if client	#2 received Amanta	dine					
	4/7/24 - 4/9/24							
	- she had not rev	viewed MARs for me	dication					
	errors since she be							
		nsible for the review	of					
		out was currently the						
	time nurse	at was sarronly the	only run					
	anto naise							
	During intention on	5/15/24 pures #2 ra	norted:					
		5/15/24 nurse #2 re	porteu.					
		elf-administer" their						
	medications							
		ed meant - clients w						
		ked their medication	S					
	beginning of the we	ek						
	- they came to th	e medication room	and					
		dication without pror						

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE SURVEY COMPLETED	
					R		
		MHL092-917	B. WING		05/2	2/2024	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
LEARNII	NG SERVICES CORPO	DRATION-WILLO\	NC 27610	ES CIRCLE			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 118	staff - staff would place cup and client woul - since the medic in the week, the MA to sign which left bl - staff will check took all medications - "we may have to about the self-admi  This deficiency con and must be correct  Due to the failure to medication administ determined if client as ordered by the p	ce the client's medication in a d take the medication cations were prepacked early AR system does not notify staff ank spaces on the MAR yes or no on the MAR if client so speak with administration nister process" stitutes a re-cited deficiency ted within 30 days.  In accurately document tration, it could not be so received their medications	V 118				
	ALTERNATIVES TO INTERVENTIONS  (a) Facilities shall i practices that empt to restrictive interved (b) Prior to providir disabilities, staff incemployees, student demonstrate completing training other strategies for which the likelihood or injury to a persor property damage is (c) Provider agence	mplement policies and nasize the use of alternatives entions.  In services to people with eluding service providers, as or volunteers, shall etence by successfully in communication skills and creating an environment in the of imminent danger of abuse in with disabilities or others or					

Division of Health Service Regulation

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NU		, ,	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
				A. BUILDING:			R	
MHL092-917				B. WING			22/2024	
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
IEADNIN	IG SERVICES CORPO		570 BUILI	DING FUTUR	RES CIRCLE			
LEARINII	IG SERVICES CORPO	DRAHON-WILLON	RALEIGH	, NC 27610				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM.	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 536	Continued From pa	ge 6		V 536				
V 536	compliance and derigathered.  (d) The training shainclude measurable measurable testing behavior) on those methods to determine course.  (e) Formal refreshed by each service programually).  (f) Content of the training provider wishes to each service programually).  (g) Staff shall demorated following core areas (1) knowledg people being server (2) recognizing behavior;  (3) recognizing external stressors training training sitting in the person decisions about the (7) skills in as escalating behavior (8) communication of the stress of the provider with programme training to the person of the person	monstrate they acted all be competency-base learning objectives (written and by observed and measure passing or failing the passing or failing that the service periodically (maining that the service periodically (maining that the service polysas pursuant to its Rule. Constrate competences:  In and understanding the and interpreting the effect of intermediate and interpreting the that may affect peopers on the importance of son's involvement in	ervation of surable of the completed aninimum are roved by the control of the con	V 536				
		ehavioral supports ( vith disabilities to cho						

Division of Health Service Regulation

STATE FORM 6899 FO8911 If continuation sheet 7 of 10

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:						(X3) DATE COMP	SURVEY LETED	
				71. BOILDING.		F	R	
		MHL092-917		B. WING		I	2/2024	
NAME OF PROVIDER	OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
LEARNING SERVI	CES CORP	ORATION-WILLO\		DING FUTUR , NC 27610	RES CIRCLE			
PREFIX (EAC	H DEFICIENC	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	S FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
activities behavion (h) Seri docume at least (1) (A) outcome (B) (C) (2) review/r (i) Instruction (3) service aimed a need for (2) by scori instruction (3) competion (5) service approve to Subp (5) shall incomplete (A) (B) course; (C)	rs which and vice provided intation of interest in three years. Documer who particles (pass/fair when and instructor The Division of the Division of the Trainers of the Trainers of the training particular of the training particular provider places, measure to the course. The contest of the training particular provider places, measure to the course. The contest of the training particular provider places, measure to the training particular provider places and the training particular places and the t	ectly oppose or replace unsafe). ers shall maintain nitial and refresher traction shall include: cipated in the training l); d where they attended is name; ion of MH/DD/SAS madecumentation at an ications and Training shall demonstrate contesting in a training g, reducing and eliminiterventions.	aining for  and the d; and hay by time.  mpetence program hating the mpetence an elearning and by tives and hing or raining the programs hation of: cr; of the	V 536				

Division of Health Service Regulation

STATE FORM 6899 FO8911 If continuation sheet 8 of 10

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				B) DATE SURVEY COMPLETED	
				R		
	MHL092-917	B. WING			2/2024	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE			
LEARNING SERVICES CORPORA	ATION-WILLO\	ING FUTUR NC 27610	ES CIRCLE			
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
teaching a training pro- reducing and eliminatir interventions at least or review by the coach.  (7) Trainers shal aimed at preventing, re need for restrictive interventions at least or review by the coach.  (8) Trainers shal instructor training at lea (j) Service providers sor documentation of initial training for at least thre (1) Documer (A) Who participal outcomes (pass/fail); (B) When and Wh (C) instructor's not provided in the course which is been competence by complete train-the-trainer instructions.	all have coached experience ogram aimed at preventing, ing the need for restrictive one time, with positive all teach a training program reducing and eliminating the erventions at least once all complete a refresher east every two years. Shall maintain all and refresher instructor ee years. Intation shall include: ated in the training and the of MH/DD/SAS may is documentation any time. Coaches: all meet all preparation iner. all teach at least three times eing coached. all demonstrate letion of coaching or	V 536				

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Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

MHL092-917    NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY. STATE, ZIP CODE	AND DUAN OF CODDECTION DENTIFICATION NUMBER.			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  LEARNING SERVICES CORPORATION-WILLON  (X4) ID PREFIX TAG  COMPLETE REQULATORY OR LSC IDENTIFYING INFORMATION)  V 536  Continued From page 9  This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure alternatives to restrictive intervention training was completed for 1 of 4 staff (nurse #1). The findings are:  Review on 5/15/24 of the nurse #1's record revealed:  - hire date of 3/3/24 - no evidence of Alternative's to Restrictive Intervention training  Interview on 5/15/24 the Operational Manager reported: - nurse #1 was scheduled for Crisis Prevention  Interview on 5/15/24 the Operational Manager reported: - nurse #1 was scheduled for Crisis Prevention				A. BOILDING.		R		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGK (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)    V 536   Continued From page 9   V 536			MHL092-917	B. WING				
(x4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 536 Continued From page 9  V 536  This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure alternatives to restrictive intervention training was completed for 1 of 4 staff (nurse #1). The findings are:  Review on 5/15/24 of the nurse #1's record revealed:  - hire date of 3/3/24 - no evidence of Alternative's to Restrictive Intervention training  Interview on 5/15/24 nurse #1 reported: - she had not taken Alternative's to Restrictive Intervention training  Interview on 5/15/24 the Operational Manager reported: - nurse #1 was scheduled for Crisis Prevention	NAME OF F	PROVIDER OR SUPPLIER						
PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  V 536  Continued From page 9  This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure alternatives to restrictive intervention training was completed for 1 of 4 staff (nurse #1). The findings are:  Review on 5/15/24 of the nurse #1's record revealed: - hire date of 3/3/24 - no evidence of Alternative's to Restrictrive Intervention training  Interview on 5/15/24 nurse #1 reported: - she had not taken Alternative's to Restrictive Intervention training  Interview on 5/15/24 the Operational Manager reported: - nurse #1 was scheduled for Crisis Prevention	LEARNIN	IG SERVICES CORPO	)RAHON-WILLOV		RES CIRCLE			
This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure alternatives to restrictive intervention training was completed for 1 of 4 staff (nurse #1). The findings are:  Review on 5/15/24 of the nurse #1's record revealed: - hire date of 3/3/24 - no evidence of Alternative's to Restrictrive Intervention training  Interview on 5/15/24 nurse #1 reported: - she had not taken Alternative's to Restrictive Intervention training  Interview on 5/15/24 the Operational Manager reported: - nurse #1 was scheduled for Crisis Prevention	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUNCED TO THE APPR	JLD BE	COMPLETE	
Based on record review and interview the facility failed to ensure alternatives to restrictive intervention training was completed for 1 of 4 staff (nurse #1). The findings are:  Review on 5/15/24 of the nurse #1's record revealed:  - hire date of 3/3/24  - no evidence of Alternative's to Restrictrive Intervention training  Interview on 5/15/24 nurse #1 reported:  - she had not taken Alternative's to Restrictive Intervention training  Interview on 5/15/24 the Operational Manager reported:  - nurse #1 was scheduled for Crisis Prevention	V 536	Continued From pa	ge 9	V 536				
	V 536	This Rule is not me Based on record refailed to ensure alternative intervention training (nurse #1). The find Review on 5/15/24 revealed:  - hire date of 3/3  - no evidence of Intervention training Interview on 5/15/24  - she had not tak Intervention training Interview on 5/15/24  - reported:  - nurse #1 was s	et as evidenced by: view and interview the facility ernatives to restrictive g was completed for 1 of 4 staff dings are: of the nurse #1's record /24 Alternative's to Restrictrive g 4 nurse #1 reported: ten Alternative's to Restrictive g 4 the Operational Manager cheduled for Crisis Prevention					

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Division of Health Service Regulation STATE FORM