STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL081-127	A. BUILDING: _____ B. WING _____	R 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOOTHILLS AT RED OAK RECOVERY	517 CUB CREEK ROAD ELLENBORO, NC 28040

(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 11/21/24. One complaint was unsubstantiated (intake # NC00222981) and one complaint was substantiated (intake # NC00223148). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600D Supervised Living for Minors with Substance Abuse Dependency. This facility is licensed for 16 and has a current census of 9. The survey sample consisted of audits of 2 current clients and 5 former clients.	V 000		
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;	V 118		

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V 118	Continued From page 1 (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure medications were administered on the written order of a physician affecting 2 of 2 audited clients (#1, #2). The findings are: Review on 11/6/24 of Client #1's record revealed: -Date of Admission: 8/12/24. -Age: 17 years old. -Diagnoses: Cocaine Use Disorder, Alcohol Use Disorder, Cannabis Use Disorder, Attention Deficit Hyperactivity Disorder (ADHD), Major Depressive Disorder, Generalized Anxiety Disorder. -There was no dated physician's order for the following medications: -Emergen-C 1000mg (milligram) (immune support) dissolve 1 packet in 8oz (ounce) water daily PRN (as needed). -Mucinex 600mg (nasal congestion) take 1 tablet twice daily PRN. -Tylenol 325mg (pain, fever, inflammation) take 2 tablets every 6 hours PRN. -Melatonin 3mg (sleep aid) take one tablet at	V 118		

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V 118	Continued From page 2	V 118		

bedtime PRN.
-Tums (calcium carbonate) 750mg (antacid) take 2 tablets every 6 hours PRN.

Review on 11/7/24 of Client #1's MARs for period 8/12/24-11/6/24 revealed:
-Emergen-C, Mucinex, and Tylenol were documented as administered on 9/24/24.
-Melatonin was documented as administered on 9/17/24 and 9/19/24.
-Tums was documented as administered on 10/3/24.

Review on 11/6/24 of Client #2's record revealed:
-Date of Admission: 10/8/24.
-Age: 15 years old.
-Diagnoses: Cannabis Use Disorder, Hallucinogen Use Disorder, Nicotine Dependence, ADHD, Post Traumatic Stress Disorder.
-There was no dated physician's order for the following medication:
-Melatonin 3mg take one tablet at bedtime PRN.

Review on 11/7/24 of Client #2's MARs for period 10/8/24-11/6/24 revealed:
-Melatonin was documented as administered on 10/11/24 and 10/14/24.

Interview on 11/6/24 with Client #1 revealed:
-Had been at the facility almost 90 days.
-Knew most of the medications he was prescribed and could request PRNs anytime he wanted.
-"Have to go to the med (medication) window and med trained staff had to administer."

Interview on 11/6/24 with Client #2 revealed:
-Was only administered one medication on a

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V 118	Continued From page 3 regular basis. He had also been administered melatonin once or twice. -"Have to show (staff) our mouths to make sure we don't cheek any (medications)." Interview on 11/7/24 with the facility's Registered Nurse revealed: - The standing orders for supplements and over the counter medications were signed by the Medical Director and a parent for each client. Was not aware these orders were not dated. This deficiency constitutes a recited deficiency and must be corrected within 30 days.	V 118		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. . This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure all medication administration errors were reported to a pharmacist or physician affecting 1 of 2 audited clients (#1). The findings are:	V 123		

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V 123	Continued From page 4 Review on 11/6/24 of Client #1's record revealed: -Date of Admission: 8/12/24. -Age: 17 years old. -Diagnoses: Cocaine Use Disorder, Alcohol Use Disorder, Cannabis Use Disorder, Attention Deficit Hyperactivity Disorder (ADHD), Major Depressive Disorder (MDD), Generalized Anxiety Disorder. -Physician ordered medications dated 8/12/24 included: -Pantoprazole 20mg (milligram) (reflux) 2 tablets daily in the morning. -Concerta 54mg (ADHD) 1 tablet daily in the morning. -Concerta 18mg (ADHD) 1 tablet daily in the morning. -Bupropion XL (extended release) 150mg (MDD) 3 tablets daily in the morning. Review on 11/7/24 of Client #1's medication administration record (MARs) for period 8/12/24-11/6/24 revealed: -Pantoprazole was documented as refused on 9/26/24 and 10/7-10/10/24. (5 doses) -Concerta 54mg was documented as refused on 8/25/24, 8/30/24, 9/1/24, 9/2/24, 9/26/24, 10/10-10/12/24, 10/14/24, 10/17/24, and 10/20/24. (11 doses) -Concerta 18mg was documented as refused on 8/25/24, 8/30/24, 9/1/24, 9/2/24, 9/26/24, 10/10-10/12/24, 10/14/24, 10/17/24, and 10/20/24. (11 doses) -Bupropion was documented as refused on 10/26/24. (1 dose) Review on 11/18/24 of Occurrence Reports of medication errors for period 8/12/24-11/6/24 revealed: -No documentation that Client #1's refusals of	V 123		

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V 123	Continued From page 5 medication for the above dates had been reported to a pharmacist or physician. Interview on 11/7/24 with Client #1 revealed: -Often refused Concerta on the weekends. "It (Concerta) 100% helps me focus so it depends on what we're doing." -" ...see the doctor weekly on Thursdays or Mondays ...he knew about refusals ..." Interview on 11/7/24 with the facility's Registered Nurse revealed: -"Some days [Client #1] just doesn't feel like he needs it (medication)." -"It's (refusals) communicated to me from direct care staff ...if it becomes a habit then I communicate to the provider (physician)." -Staff involved were required to chart clients' refusals but completed an occurrence report for missed medications or medication errors. "Refusals are not med (medication) errors." Interview on 11/7/24 with the Licensee's Director of Nursing revealed: -"Our Medical Director doesn't consider refusal as med (medication) error ...a deviation from the MAR but not an error."	V 123		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes:	V 132		

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V 132	Continued From page 6 a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report allegations of abuse, neglect or exploitation to the Health Care Personnel Registry (HCPR). The findings are: Review on 11/7/24 of an Occurrence Report dated 10/12/24 revealed: -"On Saturday morning 10/12/24 at roughly 8:30am I [Staff #1] was told by [Staff #2] that [Former Client (FC) #4] wanted to speak to me about something personal. I asked [Staff #2] to send him downstairs from his room and to meet out front (of facility on porch) for one on one communication. As we began to walk and talk	V 132		

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V 132	Continued From page 7 down the driveway from the main house to the carriage house he began to inform me of unwanted interactions with [Former Staff (FS) #4]. He told me that [FS #4] was sneaking to him to get unsupervised communication to make sexual comments. I asked [FC #4] if he could be more in depth with his statements. [FC #4] became visibly uncomfortable. [FC #4] had informed me of unwanted sexual talk and flirting from staff in training [FS #4]. I followed up with [FC #4]'s statements with support questions 'Are you okay?' 'Was anyone else involved?' [FC #4] responded with minor details of who else was effected; names listed were [FC #6] and [FC #5]. After speaking with [FC #4] I informed staff that we have a situation on site that will require clinical assistance and followed guidance from Executive Director (ED) via phone. Once I had received guidance at roughly 10:00am from [ED] I began speaking to the clients [FC #4], [FC #6] and [FC #5] individually to better understand and report the issues to supervisors. When I gathered the notes therapist [Therapist #3] had arrived roughly 10:30am and spoke to the clients as well to gather information from the clients. All information given was gathered from myself [Staff #1] and therapist [Therapist #3] and given to [ED] and waited for more guidance. Staff Interventions: Verbal: Recovery guide [Staff #1] and Primary Therapist [Therapist #3] spoke with clients privately to gather information and address concerns. Client places on observation: Clients were monitored to make sure communication of affected clients could be minimized so other clients wouldn't overhear and if they needed therapist [Therapist #3] was available for therapy sessions. Root Cause Analysis:	V 132		

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V 132	Continued From page 8 Human Error/behavior: New Hire [FS #4] inappropriate behavior. ED talked with HR (human resources) director to review background checks, sex offender check and drug screen of [FC #4]. ED reviewed onboarding protocols and shadow protocols for all new hires with program director. ED reviewed rule of three protocols with all staff. Interview with all clients involved was completed. Interviewed all staff members that were on shift with [FC #4]. Remedial Actions: [FC #4] was sent home on 10/11 (2024). Parents were updated of incident by ED on 1/12 (2024). Police were notified on 10/12 (2024) and a case was opened. ED called [local county] CPS (child protective services) to notify them of the incident. A social worker (Department of Social Services) arrived on campus to interview [FC #6] on Sunday 10/13 (2024). [FC #5], [FC #7] and [FC #4] were discharged AMA (against medical advice) due to their parents deciding to take them home. Treatment resources were provided to families. Bradford (corporate licensee) leadership and compliance were notified of incident on 10/12 (2024) by ED. Detective [detective] was assigned to the case on 10/14 (2024)..." -There was no evidence of notification to HCPR. Interview on 11/6/24 with the ED revealed: -Was ED during the 10/12/24 incident but recently stepped back into Clinical Director role. -"[FS #4] was hired as a direct care staff ...began orientation on Monday after the storm (Hurricane Helene). Tuesday he was not on campus ...came back to campus shadowing on Wednesday .... [Staff #1] and [Staff #2] were his guides in shadowing. He was super engaging in groups. Thursday am (morning), [Staff #1] had a conversation with [FS #4] about staying with him ...[Program Director (PD)] and [Student Life	V 132		

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V 132	Continued From page 9 Manager (SLM)] talked to [FS #4] about staying hip to hip with [Staff #1] ...[Staff #1] called [PD] saying I can't supervise these kids and supervise [FS #4] ...[PD] said just send him home and I'll talk to him later. On Saturday am [FC #4] reported to [Staff #1] sexual conversation and grooming ..." -" ...talked to all kids, not just those involved ...called all parents ...called law enforcement ...called DSS (Department of Social Services) ..." Interview on 11/20/24 with the Quality Assurance (QA) Officer revealed: -"Generally, all reporting of any incident is initially done at the facility level by direct care staff. Based on the severity of the incident, a supervisor or the facility leader would do the reporting to outside agencies and do an analysis of the incident. QA is a resource for them, but I was out sick during this time. I understood the ED had reported to DHHS (Department of Health and Human Services) within 24 hours. The ED misunderstood her reporting to DSS (Department of Social Services) was including the MCO (Local Management Entity/Managed Care Organization (LME/MCO)) and DHSR (Division of Health Service Regulation)." -Was not aware there were separate reporting requirements for MCO and HCPR notification but has a plan to make sure all parties and their contact information are notified within required timelines.	V 132		
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	V 367		

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	MHL081-127	A. BUILDING: _____ B. WING _____	R 11/21/2024

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V 367	Continued From page 10 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 (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;	V 367		

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V 367	Continued From page 11 (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: (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.	V 367		

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V 367	Continued From page 12 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure a Level III incident report was completed within 24 hours and submitted to the Local Management Entity/Managed Care Organization (LME/MCO) where services were provided. The findings are: Refer to V132 for details of Occurance Report dated 10/12/24 Interview on 11/6/24 with the Executive Director (ED) revealed: -Was ED during the 10/12/24 incident but recently stepped back into Clinical Director role. -"[Former Staff (FS) #4] was hired as a direct care staff ...began orientation on Monday after the storm (Hurricane Helene). Tuesday he was not on campus ...came back to campus shadowing on Wednesday ....[Staff #1] and [Staff #2] were his guides in shadowing. He was super engaging in groups. Thursday am (morning), [Staff #1] had a conversation with [FS #4] about staying with him ...[Program Director (PD)] and [Student Life Manager (SLM)] talked to [FS #4] about staying hip to hip with [Staff #1] ...[Staff #1] called [PD] saying I can't supervise these kids and supervise [FS #4] ...[PD] said just send him home and I'll talk to him later. On Saturday am [Former Client (FC) #4] reported to [Staff #1] sexual conversation and grooming ..." -" ...talked to all kids, not just those involved ...called all parents ...called law enforcement ...called DSS (Department of Social Services) ..."	V 367		

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	MHL081-127	A. BUILDING: _____ B. WING _____	R 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOOTHILLS AT RED OAK RECOVERY	517 CUB CREEK ROAD ELLENBORO, NC 28040

(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 367	Continued From page 13 Interview on 11/20/24 with the Quality Assurance (QA) Officer revealed: -"Generally, all reporting of any incident is initially done at the facility level by direct care staff. Based on the severity of the incident, a supervisor or the facility leader would do the reporting to outside agencies and do an analysis of the incident. QA is a resource for them, but I was out sick during this time. I understood the ED had reported to DHHS (Department of Health and Human Services) within 24 hours. The ED misunderstood her reporting to DSS was including the MCO (LME/MCO) and DHSR (Division of Health Service Regulation)." -Was not aware there were separate reporting requirements for MCO and HCPR notifications but has a plan to make sure all parties and their contact information are notified within required timelines.	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	V 536		

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V 536	Continued From page 14	V 536		

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
(9) positive behavioral supports (providing

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	MHL081-127	A. BUILDING: _____ B. WING _____	R 11/21/2024

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V 536	Continued From page 15 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 performance; and	V 536		

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	MHL081-127	A. BUILDING: _____ B. WING _____	R 11/21/2024

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V 536	Continued From page 16 (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 17	V 536		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure 1 of 5 audited former staff (FS #4) received initial training in alternatives to restrictive interventions prior to the provision of services and 1 of 5 audited former staff (FS #5) failed to demonstrate competency in the use of alternatives to restrictive interventions. The findings are:

Review on 11/7/24 of FS #4's record revealed:
-Date of hire: 10/7/24.
-Job Title: Recovery Guide.
-Date of Separation: 10/21/24.
-There was no documentation of training in alternatives to restrictive intervention (North Carolina Interventions Plus (NCI+) training).

Review on 11/7/24 of FS #5's record revealed:
-Date of hire: 9/9/24.
-Job Title: Lead Recovery Guide.
-Date of Separation: 10/10/24.
-NCI+ training completed 9/10/24.

Review on 11/7/24 of an Occurrence Report dated 10/1/24 involving Former Client #3 (FC #3) and FS #5 revealed:
-10/1/24: "During academic session in the computer room, clients were instructed by lead RG [FS #5] that no computer games would be played. [FC #3] would continue to try and play the game, as a response [FS #5] stated 'I am going to unplug the computer.' [FS #5] would walk over to [FC #3's] computer and unplug it, bending down to do so. [FS #5] and [FC #3] would then be face to face, as a result [FC #3] pushed [FS #5]. [FS #5] responded by placing [FC #3] in a hold and getting him to the ground.

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	MHL081-127	A. BUILDING: _____ B. WING _____	R 11/21/2024

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V 536	Continued From page 18	V 536		

[FC #3] would be prompted to verbally commit to safety, after few minutes [FC #3] would comply ...Debrief with NCI+ (North Carolina Interventions Plus) facilitator occurred to review incident. HR (human resources) was updated and staff member [FS #5] was placed on suspension ...Parents were updated. Medical follow up with client was completed. Clinical follow up with client was completed. HR (human resources) investigation occurred and staff member [FS #5] is no longer employed at Foothills (facility)."

Review on 11/7/24 of an Occurrence Report dated 10/12/24 involving FC #4, FC #5, FC #6, FC #7 and FS #4 revealed:
-10/11/24: "[FS #4] arrived on site Wednesday (10/9/24) to begin training as a new recovery guide. I, [Staff #1] was informed by my direct supervisor [Program Director (PD)] that [FS #4] was not NCI+ trained and can not be alone with the kids (clients) until the NCI+ certification was complete ...I had to repeat myself multiple times to [FS #4] that they are not to be alone with the clients until they become NCI+ certified..."

Review on 11/19/24 of email correspondence dated 11/19/24 and sent to the Division of Health Service Regulation surveyor from the facility's Quality Assurance (QA) Officer revealed:
-FS #4 worked at the facility:
-"Monday October 7th (2024) 8:30am-4pm - Orientation.
-Wednesday (10/9/24) 10am-9:40pm - Shadowed - did not stay on campus after 9:40pm.
-Arrived back at 7am on October 10th (2024) and left Friday October 11th (2024) at 10:49 pm - Shadowed until he was sent home."

Interview on 11/8/24 with the HR Manager revealed:

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 19 -" ...Typical process (for new hires) was orientation on the first day at their corporate office ...Day 2 was NCI+ training then start working on policy review and other online trainings. First aid/CPR (cardiopulmonary resuscitation) was on 3rd day." -"[FS #4] was different because we had no running water (at corporate offices); no functioning office. Typically, (new hires) will stay 3 nights in a hotel but none were open. His first day training had to be done on campus virtually. The second day, he started shadowing only. He could not be alone with clients at any time...until NCI+ training was completed." -"The reason for termination of [FS #5] was because he did not utilize the verbal de-escalation ..."	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	V 537		

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V 537	Continued From page 20	V 537		

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);
(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;

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V 537	Continued From page 21 (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. (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:	V 537		

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V 537	Continued From page 22 (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 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.	V 537		

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	MHL081-127	A. BUILDING: _____ B. WING _____	R 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 537	Continued From page 23 (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 1 of 5 audited former staff (FS #4) received initial training in seclusion, physical restraint and isolation time-out prior to the provision of services. The findings are: Review on 11/7/24 of FS #4's record revealed: -Date of hire: 10/7/24. -Job description: Recovery Guide. -Date of Separation: 10/21/24. -There was no documentation of training in seclusion, physical restraint and isolation time-out (North Carolina Interventions Plus (NCI+) training). Review on 11/19/24 of email correspondence dated 11/19/24 and sent to the Division of Health Service Regulation surveyor from the facility's Quality Assurance (QA) Officer revealed: -FS #4 worked at the facility: -"Monday October 7th (2024) 8:30am-4pm - Orientation. -Wednesday (10/9/24) 10am-9:40pm - Shadowed - did not stay on campus after 9:40pm. -Arrived back at 7am on October 10th (2024) and left Friday (October 11th (2024) at 10:49 pm - Shadowed until he was sent home." Interview on 11/8/24 with the Human Resources Manager revealed: -" ...Typical process (for new hires) was	V 537		

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	MHL081-127	A. BUILDING: _____ B. WING _____	R 11/21/2024

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V 537	Continued From page 24 orientation on the first day at their corporate office ...Day 2 was NCI+ training then start working on policy review and other online trainings. First aid/CPR (cardiopulmonary resuscitation) was on 3rd day." -"[FS #4] was different because we had no running water (at corporate offices); no functioning office. Typically, (new hires) will stay 3 nights in a hotel but none were open. His first day training had to be done on campus virtually. The second day, he started shadowing only. He could not be alone with clients at any time...until NCI+ training was completed."	V 537		