STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL013-243	A. BUILDING: _____ B. WING _____	06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE	28 STRICKER AVENUE NW CONCORD, NC 28027

(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 and complaint survey was completed on 06/24/2025. The complaint was unsubstantiated (Intake #NC00229956). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Staff Secure for Children or Adolescents. This facility is licensed for 4 and has a current census of 3. The survey sample consisted of audits of 3 current clients.	V 000		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure the North Carolina Health Care Personnel Registry (HCPR) was accessed prior to making an offer of employment for 1 of 1 Staff (#1). The findings are: Review on 06/20/2025 of Staff #1's personnel record revealed:	V 131		

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V 131	Continued From page 1 -Date of Hire: 02/18/2025. -HCPR verification check: 05/06/2025. Interview 06/24/2025 with the Qualified Professional revealed: -"I will double check (that HCPR is accessed prior to hire)." Interview on 06/24/2025 with the Licensee revealed: -"Generally, I pull the background check and HCPR at the same time. I think the paperwork got mixed up." -"Moving forward, I will match the person with the last 4 digits of the social security number before I put it (HCPR form) in the file."	V 131		
V 295	27G .1703 Residential Tx. Child/Adol - Req. for A P 10A NCAC 27G .1703 REQUIREMENTS FOR ASSOCIATE PROFESSIONALS (a) In addition to the qualified professional specified in Rule .1702 of this Section, each facility shall have at least one full-time direct care staff who meets or exceeds the requirements of an associate professional as set forth in 10A NCAC 27G .0104(1). (b) The governing body responsible for each facility shall develop and implement written policies that specify the responsibilities of its associate professional(s). At a minimum these policies shall address the following: (1) management of the day to day day-to-day operations of the facility; (2) supervision of paraprofessionals regarding responsibilities related to the implementation of each child or adolescent's treatment plan; and	V 295		

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V 295	Continued From page 2 (3) participation in service planning meetings. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to employ an Associate Professional (AP) who provided services to the facility on a full-time basis. The findings are: Review on 06/24/2025 of the AP's personnel record revealed: -Date of Hire: 06/24/2024. -Job description: Associate Professional. -Bachelor of Science unofficial transcript. -There was no resume available to verify employment history related to the population served. Attempted Interview on 06/24/2025 with the AP was unsuccessful due to no response to phone call prior to survey exit. Interview on 06/24/2025 with Client #2 revealed: " I have only seen him (AP) once and I have been here for like 8 months. That's like [Qualified Professional (QP)]'s dad. Interview on 06/24/2025 with Staff #1 revealed: -"No, I don't know him (AP)." Interview on 06/24/2025 with the QP revealed: -"He comes once a month for a shift (12 hours)." Interview on 06/24/2025 with the Licensee revealed: -"So, [QP] and I have talked about me taking on	V 295		

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V 295	Continued From page 3 the AP role due to his (current AP) inability to commit as AP."	V 295		
V 318	13O .0102 HCPR - 24 Hour Reporting 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g). This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure Health Care Personnel Registry (HCPR) was notified of all allegations of abuse against personnel within 24 hours as required affecting 1 of 1 Staff (Chef). The findings are: Review on 06/24/2025 of the Chef's personnel record revealed: -Hire date 02/05/2025. -Job title Chef. Reviews on 06/20/2025 and 06/23/2025 of the	V 318		

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V 318	Continued From page 4 facility records revealed: -There was no HCPR 24 Hour Initial Report for the allegation that the Chef interacted inappropriately with Client #2 incident dated 06/06/2025. -There was a HCPR 5-Day Working Report dated 06/08/2025. -There was a HCPR Screenout letter for the Chef dated 06/13/2025. Review on 06/13/2025 of the North Carolina Incident Response Improvement System for the facility's reports from 03/13/2025 - 06/12/2025 revealed: -There were no level III incident report for Client #2's allegation of against the Chef. Interview on 06/24/2025 with Client #2 revealed: -"I remember it very clearly. We (Chef and Client #2) went outside. He said, 'I love you so much, I want to adopt you, and I said I am already adopted, and he asked for a hug' and I gave him a hug. He touched my face. He asked for another hug, and I gave him another hug. I came back inside, and I said we had a weird conversation." -Reported the incident to the facility staff on duty the day of the incident. -Reported the incident to the Qualified Professional (QP) the next day. Interview on 06/24/2025 with the QP revealed: -"I thought IRIS would inform HCPR." -She was not aware that the IRIS report for Client #2's allegation against the Chef dated 06/06/2025 was not successfully submitted in IRIS. -She did not complete the HCPR 24 Hour Initial Report for the allegation that the Chef interacted inappropriately with Client #2.	V 318		

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V 366	Continued From page 5	V 366		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond	V 366		

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V 366	Continued From page 6 by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not	V 366		

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V 366	Continued From page 7 available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement written policies governing their response to Level II and III incidents. The findings are: Review on 06/13/2025 of the North Carolina Incident Response Improvement System for the facility's reports from 03/13/2025 - 06/12/2025 revealed: Level III: -There was no IRIS report submitted for Client #2's physical restraint incident dated 04/24/2025. -There was no IRIS report submitted for the allegation that the Chef inappropriately interacted with Client #2 incident dated 06/06/2025.	V 366		

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V 366	Continued From page 8 -There was no IRIS report submitted for the allegation that the Chef inappropriately interacted with Client #3 incident date unknown. Reviews between 06/13/2025-06/24/2025 of the facility records revealed: -There were IRIS reports for the above incidents that were not successfully submitted in IRIS; "1/1/0001" code specified on all reports. -There was no documentation to support that the above recorded incidents had been evaluated to: (A) Determine the cause of the incident. (B) Assign a person to be responsible for implementation of the corrective and/or preventive measures. Interview on 06/24/2025 with the Qualified Professional revealed: -"I thought that the supervision section was enough, but I will create a way to make sure all sections are for fulfilled for each incident."	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail,	V 367		

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V 367	Continued From page 9	V 367		

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;
(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

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V 367	Continued From page 10 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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report Level II and III incidents in the Incident Response Improvement System (IRIS) as required once of becoming aware of the incident. The findings are:	V 367		

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V 367	Continued From page 11 Review on 06/13/2025 of the North Carolina Incident Response Improvement System for the facility's reports from 03/13/2025 - 06/12/2025 revealed: Level III: -There was no IRIS report submitted for Client #2's physical restraint incident dated 04/24/2025. -There was no IRIS report submitted for the allegation that the Chef inappropriately interacted with Client #2 incident dated 06/06/2025. -There was no IRIS report submitted for the allegation that the Chef inappropriately interacted with Client #3 incident date unknown. Review on 06/23/2025 of an IRIS Report dated 04/24/2025 for Client #2 revealed: -"Date of Incident: 04/24/2025. -Date Last submitted: 1/1/0001. -Restrictive Intervention: Yes." Review on 06/23/2025 of an IRIS Report dated 06/06/2025 for Client #2 revealed: -"Date of Incident: 06/06/2025. -Date Last submitted: 1/1/0001. -Does this incident include an allegation against the facility?: Yes." Interview on 06/24/2025 with the Qualified Professional revealed: -Did not complete an IRIS report for Client #3's allegation against the Chef (date unknown). -"I thought they were fully submitted, but now I know how to check to see how. I will get further training to ensure they are submitted correctly."	V 367		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS	V 500		

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V 500	Continued From page 12 (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall	V 500		

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V 500	Continued From page 13 develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure all incidents of alleged abuse are reported to the County Department of Social Services (DSS). The findings are: Reviews on 06/20/2025 and 06/23/2025 of the facility records revealed: -There was no notification to the Local County DSS for the allegation that the Chef interacted inappropriately with Client #2 incident dated 06/06/2025. -There was no notification to the Local County DSS for the allegation that the Chef interacted inappropriately with Client #3 incident date unknown. Interview on 06/23/2025 with the Qualified Professional (QP) revealed:	V 500		

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(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 500	Continued From page 14 -"No, I didn't (notify DSS). I just did not investigation with HCPR (Health Care Personnel Registry) and left it at that (pertaining to the 06/06/2025 incident)." Interview on 06/24/2025 with the QP revealed: -"I learned about the incident (allegation that the Chef interacted inappropriately with Client #3) with [Client #2]'s incident (06/06/2025)." -"I did not know to inform DSS. Moving forward, I will notify DSS as well."	V 500		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the	V 536		

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	MHL013-243	A. BUILDING: _____ B. WING _____	06/24/2025

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V 536	Continued From page 15 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 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	V 536		

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V 536	Continued From page 16	V 536		

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
(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

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V 536	Continued From page 17 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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 1 Associate Professional (AP) completed refresher training in alternatives to restrictive interventions. The findings are:	V 536		

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V 536	Continued From page 18 Review on 06/24/2025 of the AP's personnel record revealed: -Hire date 06/24/2024. -Initial Nonviolent Crisis Prevention & Intervention (CPI) Training refresher training in alternatives to restrictive interventions expired 06/07/2025. -There was no refresher CPI Training in alternatives to restrictive interventions. Attempted interview on 06/24/2025 with the AP was unsuccessful due to no response to phone call prior to survey exit. Interview on 06/24/2025 with the Qualified Professional revealed: -She was not responsible for scheduling staff training. -The licensee was responsible for scheduling staff training. Interview on 06/24/2025 with the Licensee revealed: -"I will set up a tracking system to be on top of training expirations."	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.	V 537		

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V 537	Continued From page 19 (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (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;	V 537		

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V 537	Continued From page 20 (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (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.	V 537		

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V 537	Continued From page 21 (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the 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:	V 537		

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V 537	Continued From page 22 (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 1 Associate Professional (AP) completed refresher training in seclusion, physical restraint, and isolation time out. The findings are: Review on 06/24/2025 of the AP's personnel record revealed: -Hire date 06/24/2024. -Initial Nonviolent Crisis Prevention & Intervention (CPI) Training in seclusion, physical restraint, and isolation time out expired 06/07/2025. -There was no refresher CPI Training in seclusion, physical restraint, and isolation time out. Attempted interview on 06/24/2025 with the AP was unsuccessful due to no response to phone call prior to survey exit. Interview on 06/24/2025 with the Qualified Professional revealed: -She was not responsible for scheduling staff training.	V 537		

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V 537	Continued From page 23 -The Licensee was responsible for scheduling staff training. Interview on 06/24/2025 with the Licensee revealed: -"I will set up a tracking system to be on top of training expirations."	V 537		