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INDEPENDENT LIVING AT RANSOM RD	355 RANSOM ROAD WINSTON SALEM, NC 27106

(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 April 20, 2018. The first complaint (Intake #NC00136347) was substantiated. The second complaint (intake #NC00136592) was unsubstantiated and the third complaint (Intake #NC00137112) was unsubstantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600B Supervised Living for Minors Whose Primary Diagnosis is a Developmental Disability.	V 000		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have	V 291		

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V 291	Continued From page 1 activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility staff failed to coordinate services with those responsible for 1 of 3 clients (#1). The findings are: Review on 3/8/18 of client #1's record revealed: -An admission date of 12/28/16 -Diagnoses of Oppositional Defiant Disorder, Mild Mental Retardation, Attention Deficit Hyperactivity Disorder and Nocturnal Enuresis. -Age 17 -An assessment dated 12/28/16 noting, "needs assistance with nail care, getting in/out of bed, skin care, completing personal care/tasks, needs to increase his ability to identify and implement positive coping skills to assist with managing behaviors, needs to demonstrate patience and flexibility by following a schedule that allows for 10 minute ranges, struggles with impulse control and may exhibit physical aggression or elopement and property destruction, requires close supervision and monitoring at all times" -A treatment plan dated 11/1/17 noting "will actively participate in assigned tasks, will use positive coping skills to manage frustrations and anxiety, use positive social and communication skills and increase interest in social interactions with peers, family and staff." -A behavior support plan dated 7/3/17 noting "requires day supports to ensure health and	V 291		

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V 291	Continued From page 2 safety, should have close visual proximity and monitoring at all times, he should at arm's length in the community. Disruptive behaviors included: physical aggression (hitting/kicking/scratching/biting others), verbal aggression (yelling, cursing and/or threatening verbal statements), Self-Injurious Behaviors (scratching, hitting self or other similar behavior directed towards or causing self-harm), elopement (leaving unsupervised areas) and inappropriate social behaviors (lying and/or making false allegations). Triggers are: talking to family, prompted to leave school, not getting his way, will get fidgety, talk under his breath, make loud noises, will tell you when he is agitated, shuts down and his face turns red. To prevent possible harm, secure sharps, chemicals and coat hangers. All staff working with [client #1] will be in-serviced on how to implement this program. Staff will document episodes of disruptive behaviors requiring intervention. Staff are to follow company policies as it relates to emergency procedures in all matters to include behavior intervention." Review on 3/15/18 of the facility's internal incident report for client #1 revealed: -"On 2/18/18 at 9:30am, [client #1] was having a behavior and started banging his head on the wall and floor. Staff immediately did a therapeutic hold. While in the therapeutic hold, consumer fell to the ground and started banging his head on the floor. He has marks on his face and elbow due to him banging his head on the floor." -Further review of the facility's internal incident report described as medical care: "Ice pack and alcohol pad." Review on 3/8/18 of the photographs of client #1's injuries, taken by school personnel on	V 291		

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V 291	Continued From page 3 2/20/18, revealed: -A 3 inch abrasion on the left side of his face, covering his cheek bone, stretching from the eye to the end of his side burn. -A 3 inch abrasion on the right side of his face, covering his cheek bone, stretching from the eye to the end of his side burn. -The left eye had a dark bruise underneath it -An abrasion over the right eyebrow -A blackish bruise around the right eye -Abrasions on his left forearm and elbow -Scratches and abrasions to the top of his left foot. Review on 3/8/18 of documentation written by the school social worker at client #1's school revealed: -"On 2/20/18 (Tuesday), [client #1] came into guidance first thing with several facial injuries. These injuries are much more substantial than last week. Injuries included blackened eyes (in the corners and underneath), blood pooled in the corner of the white of his right eye, very large rug burn type lacerations on his left cheek, right cheek lacerations (rug burns), and foot raw spots ...when asked, [client #1] stated [staff #1] had restrained him (on Sunday, 2/18/18)." Observations and interview on 3/8/18 with client #1, at approximately 10:10am, revealed: -Pink healing skin on both sides of his face, light greenish bruise under and over his right eye, healing abrasions on his left forearm and on his left foot. -Stated staff #1 pulled him out of his bed, banged his head against the floor and then sat on his back with his arms behind him. -Client #1 adamantly denied staff #1 used an ice pack or an alcohol pad. -No medical treatment by a medical doctor was	V 291		

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V 291	Continued From page 4 sought for his injuries. Interview on 3/15/18 with staff #1 revealed -Restrained client #1 on Sunday, 2/18/18 due to self-injurious behaviors (head banging). -Described client #1's injuries as 2 knots and abrasions on both sides of his temples and a carpet burn on the left side of his jawline which bled. -"His injuries did not look that bad, but when I saw him the next day (2/19/18) on my shift, the knots on his temples were swollen and red. Both of his eyes were black near the end of his eyelids." -No medical treatment was sought for client #1 injuries Interview on 3/20/18 with the Qualified Professional revealed: -When asked about injuries to client #1, the QP stated client #1 did not mention he was harmed. -"I saw [client #1] on Monday (2/19/18) after the restraint and he had scratches and abrasions to both sides of his face and a scratch on his elbow ...I know [staff #1] did a body check form and he was not assessed for any medical treatment ..." Interview on 3/8/18 with the Licensee #1/Registered Nurse (L#1/RN) revealed: -Was aware of the incident with client #1 and staff #1 on 2/18/18 -Had not seen the injuries (abrasions) on client #1 until several days later -Described the injuries as superficial -Client #1 was not assessed for his injuries by a Medical Doctor This deficiency is cross referenced into 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (V537) for a Type A1 rule violation and	V 291		

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V 291	Continued From page 5 must be corrected within 23 days.	V 291		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of 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	V 537		

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V 537	Continued From page 6	V 537		

provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.
(g) Acceptable training programs shall include, but are not limited to, presentation of:
(1) refresher information on alternatives to the use of restrictive interventions;
(2) guidelines on when to intervene (understanding imminent danger to self and others);
(3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention);
(4) strategies for the safe implementation of restrictive interventions;
(5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention;
(6) prohibited procedures;
(7) debriefing strategies, including their importance and purpose; and
(8) documentation methods/procedures.
(h) Service providers shall maintain 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

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V 537	Continued From page 7 by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (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.	V 537		

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V 537	Continued From page 8 (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility staff failed to demonstrate competence in restrictive interventions for 2 of 6 staff (#1 and #2). The findings are: Cross Reference: 10A NCAC 27G .5603 OPERATIONS (V291). Based on observations, record reviews and interviews, the facility staff failed to coordinate services with those responsible for 1 of 3 clients (#1).	V 537		

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V 537	Continued From page 9 Review on 3/14/18 of staff #1's record revealed: -A hire date of 8/1/11 -A job description of Paraprofessional -A North Carolina Intervention (NCI) Core + training certificate dated 5/20/17 Review on 3/14/18 of staff #2's record revealed: -A hire date of 8/5/15 -A job description of Paraprofessional -A NCI Core + training certificate dated 8/26/17 Review on 3/8/18 of client #1's record revealed: -A admission date of 12/28/16 -Diagnoses of Oppositional Defiant Disorder, Mild Mental Retardation, Attention Deficit Hyperactivity Disorder and Nocturnal Enuresis. -Age 17 -An assessment dated 12/28/16 noting, "needs assistance with nail care, getting in/out of bed, skin care, completing personal care/tasks, needs to increase his ability to identify and implement positive coping skills to assist with managing behaviors, needs to demonstrate patience and flexibility by following a schedule that allows for 10 minute ranges, struggles with impulse control and may exhibit physical aggression or elopement and property destruction, requires close supervision and monitoring at all times" -A treatment plan dated 11/1/17 noting "will actively participate in assigned tasks, will use positive coping skills to manage frustrations and anxiety, use positive social and communication skills and increase interest in social interactions with peers, family and staff." -A behavior support plan dated 7/3/17 noting "requires day supports to ensure health and safety, should have close visual proximity and monitoring at all times, he should be at arm's length in the community. Disruptive behaviors	V 537		

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V 537	Continued From page 10 included: physical aggression (hitting/kicking/scratching/biting others), verbal aggression (yelling, cursing and/or threatening verbal statements), Self-Injurious Behaviors (scratching, hitting self or other similar behavior directed towards or causing self-harm), elopement (leaving unsupervised areas) and inappropriate social behaviors (lying and/or making false allegations). Triggers are: talking to family, prompted to leave school, not getting his way, will get fidgety, talk under his breath, make loud noises, will tell you when he is agitated, shuts down and his face turns red. To prevent possible harm, secure sharps, chemicals and coat hangers. All staff working with [client #1] will be in-serviced on how to implement this program. Staff will document episodes of disruptive behaviors requiring intervention. Staff are to follow company policies as it relates to emergency procedures in all matters to include behavior intervention." Finding #1 Review on 3/15/18 of the facility's internal incident report for client #1, written on 2/18/18 by staff #1, revealed: -"On 2/18/18 at 9:30am, [client #1] was having a behavior and started banging his head on the wall and floor. Staff (#1) immediately did a therapeutic hold. While in the therapeutic hold, consumer fell to the ground and started banging his head on the floor. He has marks on his face and elbow due to him banging his head on the floor." Review on 3/8/18 of the photographs of client #1's injuries, taken by school personnel on 2/20/18, revealed: -A 3 inch abrasion on the left side of his face, covering his cheek bone, stretching from the eye to the end of his side burn.	V 537		

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V 537	Continued From page 11 -A 3 inch abrasion on the right side of his face, covering his cheek bone, stretching from the eye to the end of his side burn. -The left eye had a dark bruise underneath it -An abrasion over the right eyebrow -A black eye around the right eye -Abrasions on his left forearm and elbow -Scratches and abrasions to the top of his left foot. Review on 3/8/18 of the GC #1's documentation revealed: -On 2/20/18, "[Client #1] came into guidance first thing with several facial injuries. These injuries are much more substantial than last week. Injuries include blacked eyes (in the corners and underneath), blood pooled in the corner of the white of his right eye, very large rug burn type lacerations on his left check, right cheek lacerations (rug burns) and foot with raw spots. [Client #1] was not in school on Monday (2/19/18) ...he reported to me that he had hit is head on the floor and the wall. He stated [staff #1] had to restrain him ...photographs were taken of his injuries." Observations and interview on 3/8/18 with client #1, at approximately 10:10am, revealed: -Pink healing skin on both sides of his face, light greenish bruise under and over his right eye, healing abrasions on his left forearm and on his left foot. -Things were not going well at the facility with staff #1 -"She (staff #1) banged my head against the floor. She pulled me off my bed because I would not get up." -It started out as a "therapeutic wrap" -Demonstrated he was sitting on the floor with staff #1 standing over him	V 537		

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V 537	Continued From page 12 -"It was daytime on a Sunday. I tried to get out of the wrap and my head went to the floor. My stomach was on the floor and so was my head." -Further stated staff #1 was cussing at him and then crossed his legs over one another. -"Then she (staff #1) sat on my back. She held my arms behind my back and sat on me. Her butt was on my back." -Was afraid of staff #1 Interview on 3/8/18 with client #2 revealed: -Client #1's face turned red from the carpet burns -Staff #1 did a therapeutic hold on client #1 (on 2/18/18) -"[Client #1] was asleep (in his bed). [Staff #1] snatched him out of his bed and told him to clean up his room. He wouldn't, so she pulled him down on the carpet. I heard [client #1] yelling. She held his hands behind his back with one hand and he was face down. He was trying to get loose and was turning his head back and forth. His stomach was on the ground. I think he got in trouble for tearing something up." Interview on 3/8/18 with client #3 revealed: -Client #1 had marks on his face. -"I saw [staff #1] on top of [client #1] and his stomach was on the ground (2/18/18). She had his hands behind his back. Sometimes, [client #1] will rub his head on the carpet to try and get away and he will bang his head too." Interview on 3/8/18 with the GC #1 revealed: -"[Client #1] stated [staff #1] pulled him off the bed and beat his head on the floor." -Was told by client #1 the injuries occurred on Sunday (2/18/18), -Client #1 was not in school on Monday (2/19/18) -"On Tuesday (2/20/18) was when I spoke with him and saw his injuries."	V 537		

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INDEPENDENT LIVING AT RANSOM RD	355 RANSOM ROAD WINSTON SALEM, NC 27106

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V 537	Continued From page 13 -Client #1 has had injuries to his face two separate times in the month of February 2018 (On 2/13/18 and 2/20/18) -"He self-reported his injuries (on 2/20/18) and I took photographs). He stated he was pulled off the bed by a facility staff and was restrained face down. He said [staff #1] put his hands behind his back and sat on him." -When client #1 was interviewed by the GC #1 "I made sure when he demonstrated what occurred and I asked questions just to make sure I understood how the restraint occurred (face down)." -The next day, 2/21/18, client #1 recanted his story and stated he banged his head on the floor which caused the injuries. Interview on 3/8/18 with Guidance Counselor #2 revealed: -Client #1 came to school on a Tuesday (2/20/18) and school personnel observed his injuries. -Was not in school on Monday (2/19/18). -"When I spoke with him (on 2/20/18) about what happened, he said [staff #1] pulled him off his bed and restrained him. His injuries were quite prominent and he had numerous abrasions on his face and bruising to his eyes." Interview on 3/8/18 with the School Resource Officer (SRO), revealed: -This was his first encounter with client #1 -"On 2/20/18, I (SRO) observed scratches and abrasions on both sides of his face, one of his eyes was blood shot and the other eye had a dark bruise and several scratches on his feet." Interview on 3/13/18 with the Child Protective Services (CPS) Investigator revealed: -She observed injuries on client #1 on 2/20/18 -"I saw abrasions to both his right and left	V 537		

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temples, black eyes, a scrape underneath his chin on the left side and 3 blisters on his feet. He stated the blisters came from his shoes."
-Stated he was put in a "strong" therapeutic hold by staff #1
-"[Client #1] told me during his interview [staff #1] was the only staff present on 2/18/18. She placed her elbow in his back as he was banging his head on the floor and he was on his stomach."
-Had interviewed staff #1
-"I was told by [staff #1] [client #1] was banging his head and she put her forearm between his head and the wall to soften the blows. She stated he was on his stomach. Then [client #1] began to spit."
-Staff #1 told the police she had client #1 in "a lock" from behind.
-Had interviewed the other two clients at the facility.
-"[Client #2] told me [client #1] was put in a therapeutic hold that day (2/18/18), and [staff #1] tightened the hold."
-Client #3 stated he heard client #1 hollering in his room
-"[Client #3] stated [client #1] bangs his head on the floor. He further stated [client #1] was moving around on the floor and got rug burns on his face."
-The CPS investigator stated she had been training in NCI Core +
-"They (facility staff) are calling it a therapeutic hold when it was not."

Interview on 3/13/18 with the responding officer revealed:
-Had interviewed client #1 at school on 2/20/18
-"He said the staff member on duty that day (2/18/18), [staff #1], had grabbed him by his legs and threw him on the floor. Apparently, [staff #1] held him down and put her knee in his back is

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V 537	Continued From page 15 what [client #1] demonstrated to me. His statements were 'out of the blue' and there was no provocation." -Also interviewed client #1 a second time at the facility as he got off the school bus. -"He recanted his story and stated he had lied." -Had interviewed staff #1 on 2/20/18 at the facility and "she reported that on 2/18/18, she was fixing breakfast, called [client #1] to come and eat and he refused. [Staff #1] went into his room, started to exit and then she heard a banging sound." -Staff #1 placed her hand between client #1 and the wall to soften the blows. -"[Client #1] was struggling and she (staff #1) did a therapeutic 'hug' and grabbed him from behind. [Staff #1] stated they fell to the ground and he was underneath her." -Stated staff #1 was trying to hold client #1's head off the ground to stop him from banging his head. -"She demonstrated [client #1] was on his stomach while she held his head." -Had worked with this client and made numerous visits to the facility in the past. -"[Client #1] has violent behaviors either after he speaks with his family or when they leave after a visit." -Stated from a criminal side, when he had responded to the facility, "staff always explained they were trying to prevent [client #1] from harming himself due to self-injurious behaviors. They may not do the therapeutic 'hugs' the way they were trained." Observation and interview on 3/15/18, at approximately 10:40am, with staff #1 revealed -Was trained in NCI Core +, client #1's behavior support plan and his cross system support plan -Had been with the company seven years but began working at the facility on 10/17/17 with client #1	V 537		

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V 537	Continued From page 16 -She had restrained client #1 two times since she began working with him -Worked alone at the facility on 2/18/18 from 6am to 10am -Called client #1 to come and eat breakfast but he refused -"I walked to his bedroom to check on him to see if he wanted to talk. He stated 'no' so as I was walking out of his bedroom, he started to beat his head on the wall." -Client #1 banged the left side of his face "hard" on the wall. -"I put him in a therapeutic hold to stop his behaviors and he went to the ground on his stomach. I let go as he fell from his bed to the floor. I was not going to let him beat his head." -When client #1 was beating his head on the floor, "I squatted down where he was on his stomach and put my hands under his head to prevent injuries (Demonstrated both hands, palm up, between client #1's head and the floor). He had banged both sides of his face. He had his arms underneath him in a crossed position." -Client #1 attempted to raise his bed with his feet while on the floor -"He was trying to get me off him and I did not touch his legs or feet." -Described client #1's injuries as 2 knots and abrasions on both sides of his temples and a carpet burn on the left side of his jawline which bled. -"His injuries did not look that bad, but when I saw him the next day (2/19/18) on my shift, the knots on his temples were swollen and red. Both of his eyes were black near the end of his eyelids." -Stated the other two clients in the facility came to client #1's room. -"They saw me sitting next to [client #1] while he was on the floor." -Denied pulling client #1 off his bed and putting	V 537		

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V 537	Continued From page 17 him in a prone restraint. Interview on 3/20/18 with the Qualified Professional (QP) revealed: -Staff #1 made him aware of the incident at the facility on 2/18/18 -Client #1 woke up and was not in a good mood. -Staff #1 used voice prompts for him to take his medications and to eat breakfast -Staff #1 walked into client #1's room to talk with him and as she left, client #1 stated banging his head. -Stated staff #1 attempted to get client #1 into a therapeutic wrap to prevent injuries to himself -"[Client #1] slid to the ground and dropped and continued to bang his head. [Staff #1] got down with [client #1] and tried to hold his head up to prevent damage." -When asked about injuries, via telephone, client #1 did not mention he was harmed on 2/18/18. -"I saw [client #1] on Monday (2/19/18) after the restraint and he had scratches and abrasions to both sides of his face and a scratch on his elbow ...I know [staff #1] did a body check form and he was not assessed for any medical treatment ..." Further interview on 4/20/18 with the QP revealed: -He knew staff #1 did not do an improper restraint with client #1 on 2/18/18. -"How can you base your findings of an improper restraint off of two clients' statements? She (staff #1) never held his head down. She cushioned his head ..." Interview on 3/8/18 with the Licensee #1/Registered Nurse (L#1/RN) revealed: -Was aware of the incident with client #1 and staff #1 on 2/18/18 -Staff #1 was still off rotation	V 537		

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V 537	Continued From page 18 -The QP had completed the internal investigation Further interview on 4/20/18 with the L#1/RN revealed: -"Any time there is a hold/therapeutic intervention, staff is to either call [the QP] or me to assess for injuries. I was told [client #1] was not put in a hold (on 2/18/18) by [staff #1] ..." Finding #2 Review on 3/15/18 of the facility's video footage, without audio, revealed: -The camera view was of the living room, window to the kitchen on the right, library in center of the frame and the front entry door on the left -The video was dated 3/11/2018 -Staff present in the video were staff #5, the Licensee #1/Registered Nurse (L#1/RN), staff #2 and the Crisis Mobile Staff (CMS) -Staff #5 was sweeping the facility, the L#1/RN was sitting on the couch, the CMS was at the table and no clients were visible. -Staff #2 entered the living room and then left. -Client #1 is seen coming from the hallway to the library. -Staff #2 walked to the library and spoke with client #1 -Staff #2 is out of view -Client #1 is partially out of view -Staff #2 came out of the library and back in quickly -The CMS stood up and faced the library while staff #5 continued to sweep -Staff #2 exited the library and re-entered. -Client #1 had the hand held telephone with the cord in hand and backed out of camera view. -Staff #2 held the cord and walked out of the camera's view -The CMS continued looking toward the library -The CMS made a phone call and stepped back	V 537		

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V 537	Continued From page 19 to the far side of the living room from the library -Staff #2 was visible in the library replacing the hand held phone set on the wall and then out of view -Staff #5 and the L#1/RN go to the library door way while the CMS walked toward the library and was at the table. -The CMS was still on the phone when she went to the library's doorway and staff #5 and the L#1/RN are still in the doorway. -Staff #2 and client #1 were not visible. -Once client #1 is visible, he appeared to lunge towards the CMS who backed up -Client #1 then attempted to walk around the L#1/RN and staff #5 -Staff #5 and the L#1/RN stepped in front of the CMS worker and stood in between client #1 and the CMS -Staff #2 was behind client #1 and began attempting to place client #1 in a standing therapeutic hold -The facility's front door opens and the Licensee #2 entered -Staff #2 attempted to wrap his arms around client #1 in what looked like a bear hug, -Then staff #2 had his arms under client #1's arm and client #1 began to fall backwards on to the ground. -Staff #2 put client #1 on his bottom -Client #1 then rolled onto his side -Staff #2 was bending over client #1 -Client #1 turned on his side with staff #2 behind his back with his hands on client #1's back. -Staff #2 kneeled on the floor where client #1 was lying. -Client #1 remained on his side for several minutes -The ironing board in the library fell over and was removed from the room several seconds later by the L#1/RN.	V 537		

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V 537	Continued From page 20 -Staff #2 and Licensee #2 kneeled by client #1 and appeared to talk with him -Staff #2 and Licensee #2 stood up and backed away from client #1 -Client #1 sat up with his back to the wall and reached for a chair -Staff #2 stepped toward client #1 and put his hand on the chair. -Staff #2 released the chair and stepped back as client #1 turned on his side. -Licensee #2 walked over to client #1 and stood with staff #2 over client #1 Review on 3/15/18 of client #1's internal incident report, dated 3/11/18 at 1:30pm, revealed: -"[Client #1] became violent with staff and representative [from a crisis unit]. Made verbal threats. Staff (#2) put client in a therapeutic hold and 'took consumer down' after consumer approached in a threatening manner ..." Review on 3/15/18 of client #1's discharge papers from a local hospital, dated 3/14/18, revealed: -Reason for visit: "alleged child abuse" -Diagnoses: "Assault and encounter for examination and observation following alleged physical abuse." -Imaging tests: "X-ray to left elbow" Observations and interview on 3/14/18, at approximately 10:18am, with client #1 revealed: -A black bruise to his right knee, a large purplish bruise on the upper right thigh, bruises up and down the right arm, abrasions to both elbows and bruising on his left knee. -"I called the crisis hotline because I wanted to hurt myself (on 3/11/18)." -"She (the CMS) came out. She saw that I was acting up and saw [staff #2] put me in a therapeutic hold ..."	V 537		

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V 537	Continued From page 21 -Stated staff #2 had put his arms around client #1 (Client #1 demonstrated a bear hug) -As client #1 was being restrained by staff #2, he demonstrated the he was in a seated position on his bottom and then placed on the floor where he was lying on his side. -"I don't feel safe there (at the facility). I wish I had an x-ray of my thigh because it hurts. I think I need to go somewhere else, like a foster home." Interview on 3/14/18 with the CPS social worker revealed: -Was made aware of new injuries to client #1 on 3/12/18 -There was a video of the restraint on 3/11/18 -Was unable to determine, so far, how client #1 sustained injuries Interview on 3/14/18 with client #1's Exceptional Children's Teacher revealed: -Client #1 came to school on Tuesday 3/13/18, with injuries, as school was closed for inclement weather on 3/12/18. -"He stated [staff #2] put him in a therapeutic hold on the floor." Interview on 3/16/18 with client #1's Children's Clinical Coordinator revealed: -Had worked with client #1 since December 2017 -His agency was responsible for client #1's Cross System Behavior Plan which does not use physical restraints -"Our crisis plans do not include physical restraints. Our involvement on the crisis side is to assist the facility staff with early intervention strategies and verbal de-escalation with the client. -Went to the group home in December 2017 and noticed "significant carpet burns" to client #1's face. -When asked about his injuries (in December	V 537		

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V 537	Continued From page 22 2017), "[Client #1] told me he banged his head on the carpet and facility staff had not harmed him. I did review the facility's documentation ..." -His agency had not addressed client #1's head banging behaviors but would address it during the next treatment team meeting on 3/20/18. Interview on 3/15/18 with the CMS for client #1 revealed: -Worked on 3/11/18 as the crisis line's on call worker -Responded to the facility on 3/11/18 to assess client #1. -Stated he was hearing voices and had made verbal threats to harm others -Present at the facility on 3/11/18 were staff #2, staff #5, the L#1/RN in addition to herself -Client #1 was in the library area, picked up a pencil, made verbal threats to harm the CMS and physically lunged at her. -"[Staff #2] put [client #1] in a restraint. It was not a 'legal hold' because I have been trained in NCI." -Client #1's held his head up so "he was not at risk of suffocating." -After the restraint, the CMS observed rug burns on client #1's face. Observation and interview on 3/14/18 with staff #2 revealed: -Was trained in NCI Core +, client #1's behavior support plan and his cross system support plan -Worked at the facility on 3/11/18 from 6am to 2pm -Worked with client #1 since his admission date of 12/28/16 -Client #1 was acting erratic on 3/11/18 and defecated in the library area of the facility -Client #1 called 911 from the telephone in the library and stated he wanted to kill himself due to hearing voices	V 537		

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V 537	Continued From page 23 -The CMS arrived around 12:15pm on 3/11/18 -"He told [the CMS] he was hearing voices, grabbed a pencil and stated he was going to kill her." -A second later he lunged at the CMS with the pencil. -"I was behind [client #1] when he started to lunge and I instinctively grabbed [client #1] and put him on his butt. He went onto his back and spun around." -Demonstrated a bear hug position without his arms overlapping. -"[Licensee #2] saw that I was restraining him and started to coach him (verbal de-escalation). [Licensee #2] got him off the floor and I set him in a chair." -Stated he did not have client #1 in a prone position as he was "lying on his side." -Staff #5 was sweeping the facility, observing and did not intervene in the restraint but watched. Interview on 3/15/18 with staff #5 revealed: -Was present on 3/11/18 when client #1 was restrained -Client #1 had a "temper tantrum" because he could not use the phone -"We (facility staff) tried to calm him down and have him sit down. He attempted to pull his pants down as he had previously defecated on the floor. He lunged at [the CMS] and [the L#1/RN]. I stood in between them and [client #1]. [Staff #2] was behind [client #1] and did a therapeutic wrap. He (client #1) went to the floor and was moving aggressively ...[client #1] turned onto his side and laid there until he calmed down ..." Interview on 3/19/18 with the NCI Core + Instructor for the facility, revealed: -Had trained facility staff on appropriate restraints -Had shown the facility staff how to restrain a	V 537		

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client from the behind if they were attempting to charge at a person
-"With a restraint, where a staff is behind a client, staff are taught to go over the top of the consumer's shoulders, not underneath them. The idea is to not pin their arms like you are going to pick them up, but rather put their arms to their sides. No one should do what you are described."
-Stated he did not teach facility staff to go under the arm pits.
-"Once the client's hands are down you are to release them and step away. You should not sit them on their butt and then onto their side like you described. That is an improper restraint."

Interview on 3/14/18 with the L#1/RN revealed:
-Was present at the facility on 3/11/18 when staff #2 restrained client #1
-There was video tape of the incident on 3/11/18 with client #1
-The CMS had spoken on the phone with client #1 prior to her arrival as client #1 made threats of self-harm.
-Upon arrival, client #1 was non-compliant with the worker and threatened her with a pencil.
-"I ran into the library (at the facility) and [client #1] threatened to hit [the CMS]. [Staff #2] put him in a therapeutic wrap from behind. They went to the ground. It was like a bear hug. [Staff #2] did not release [client #1] from the wrap. [Client #1] tried to bang his head on the floor and [the Licensee #2] was on the floor with [client #1] trying to get him to stop ..."
-Stated she would call the restraint improper, but "he (staff #2) was trying to be chivalrous."
-When asked about the new injuries to client #1, "I honestly have no idea how or when those injuries occurred."

Interview on 3/15/18 with Licensee #2 revealed:

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V 537	Continued From page 25 -Was present at the facility on 3/11/18 -Client #1 had smeared feces in his room and defecated on the floor in the kitchen -Client #1 started head banging and "we tried to protect his head by trying to control his hands." -Client #1 charged the CMS with a pencil and then threatened her -"[Staff #2] was behind [client #1] and attempted a 'basket hold.' [Client #1] slid to the floor on his butt and then he went to his right side on the floor. He was always on his side and never on his stomach ..." -Facility staff had been trained in the "blocking technique" to prevent injury to the clients and the staff. -Did not think it was an improper restraint as facility staff were taught maneuvers from the NCI Core + Instructor. Review on 3/8/18 of the facility's plan of protection, dated 3/8/18 and written by the QP, revealed: -What immediate action will the facility take to ensure the safety of the consumers in your care? "Immediately, all staff will be retrained on Abuse and Neglect/Code of Conduct to ensure staff are continuing to rationally detach themselves when managing violent behaviors. Staff will be retrained to ensure that they understand the expectations of conduct as defined by the State of North Carolina. All staff will be retrained on how to better de-escalate consumers in the event of a possible peak behavior. Staff will be retrained on NCI (North Carolina Intervention) techniques and what is not acceptable. All staff will understand that therapeutic holds/face down restraints are not to be done on the floor. If the consumer slides down in the attempt, and staff are trying to help them from getting physically aggressive, staff will let consumer go. Staff will be retaught early	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-309	A. BUILDING: _____ B. WING _____	04/20/2018

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prevention strategies as listed in the consumers' plan of care and behavior support plan if applicable."
-Describe your plans to make sure the above happens. "To protect consumers from abuse, neglect, and exploitation, the agency will follow its policies and procedures and remove staff from the schedule until investigation is complete. Effective 3/8/18, [staff #1] will be removed from the schedule at Independent Living @ Ransom Road."

Review on 3/14/18 of the facility's Addendum to their Plan of Protection, written and dated 3/14/18 by the Qualified Professional revealed:
-What immediate action will the facility take to ensure the safety of the consumers in your care? "Effective 3/14/2018 to protect the consumers from alleged abuse, all staff who have been alleged of abuse at Independent Living @ Ransom Road will be suspended immediately until the investigation is complete."
-Describe your plans to make sure the above happens. "Staff will be retrained on abuse, neglect and exploitation. Staff will continue to be trained on early prevention strategies as listed in consumers' plan of care. Staff will continue to be taught the correct ways to do a therapeutic hold to help minimize injuries or improper restraints utilized. Therapeutic holds are not done on the floor. In the event of attempting to place a consumer in therapeutic hold and the consumer slides to the floor, staff should let them go. [The Qualified Professional #2] will oversee making sure the above recommendations are completed."

.Client #1 had a history of disruptive behaviors which included: physical and verbal aggression and self-injurious behaviors. Staff #1 had been

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trained in client #1's behavior support plan and NCI Core +. On 2/20/18 client #1 went to school with numerous abrasions and bruises. On 2/20/18, client #1 made statements to a law enforcement officer staff #1 grabbed him by the legs and threw him on the floor and put her knee in his back. Staff #1 stated to the law enforcement officer client #1 was struggling, grabbed him from behind and both fell to the ground with client #1 underneath her. Client #2 and #3 both observed the improper restraint. Client #2 witnessed staff #1 pull client #1 onto the floor, saw his hands held behind his back and client #1 was face down. Client #3 stated staff #1 was on top of client #1 with his stomach on the ground. No medical treatment was sought for client #1's injuries which included pink healing skin on both sides of his face, light greenish bruise under and over his right eye, healing abrasions on his left forearm and on his left foot. On 3/13/18, client #1 arrived at school with more injuries which included -A black bruise to his right knee, a large purplish bruise on the upper right thigh, bruises up and down the right arm, abrasions to both elbows and bruising on his left knee. Client #1 stated he was restrained by staff #2 (On 3/11/18). The facility's video recording, dated 3/11/18 showed staff #2, staff #5, the L#1/RN and the CMS present prior to the restraint and later Licensee #2 arrived. Client #1 lunged towards the L#1/RN and the CMS, stopped and then staff #2 attempted a standing therapeutic wrap that resulted in client #1 falling back and being placed on his bottom and then onto his side by staff #2. An interview with the NCI Core + instructor for the facility revealed he had trained the facility staff on appropriate restraints and also how to restrain a client from the behind if they were attempting to charge at a person. The facility staff were taught to go over the top of the

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V 537	Continued From page 28 consumer's shoulders, not underneath and once a clients' hands were down, facility staff were to release the client and step away. Staff were not to put a client in a seated position on their bottom and then onto their side as this was considered an improper restraint. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day	V 537		
V 738	27G .0303(d) Pest Control 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (d) Buildings shall be kept free from insects and rodents. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility staff failed to keep the facility free from insects. The findings are: Observations on 4/5/18, at approximately 8:59am, of the outside of the facility revealed: -A pest control vehicle parked in the driveway Review on 4/5/18, of an inspection report for the facility, dated 4/5/18, from the pest control company revealed: -"Inspected areas of concern for bedbugs. Evidence of bed bugs in all rooms, including live	V 738		

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activity, feces and eggs. Evidence of bed bugs in front room of house, residence on furniture, including feces. Evidence on mattresses, box boards, headboards, footboards and bed frames. Infestation level is moderate."

Interview on 4/5/18 with client #1 revealed:
-Saw bed bugs in his bedroom
-"I saw them in my bed. They are black. I have had them for one week and my back itches."

Interview on 4/5/18 with client #2 revealed:
-There were bedbugs in client #1's room and the couch in the living room.
-"They are reddish brown and flat."

Interview on 4/5/18 with the inspector for the pest control company revealed:
-Had inspected the facility on 4/5/18, but had not treated it.
-Found evidence of moderate infestation
-"Moderate infestation means I saw one or more and up to 20 live bugs with feces and eggs. The next course of action is to have treatment. If the clients are sleeping there, where there are live bed bugs, it could make them sick. The bed bugs must have a host. They breed two times per year and one egg capsule can hold 5 to 10 bed bugs. They will be engorged with blood."
-The facility needed to be treated for the bed bugs

Interview on 4/5/18 with the Licensee #2 revealed:
-On 4/4/18 he was notified by a staff member the facility may have bedbugs
-"I went to [a hardware store] and bought a bunch of stuff (to aid in getting rid of the bedbugs). I went into [client #1]'s bedroom and I did not see anything. Some of our other facilities have had

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V 738	Continued From page 30 them in the past ..." -On 4/5/18, had the pest control company come out to assess the facility for bedbugs -"If there are bedbugs, I will schedule treatment." Interview on 4/20/18 with Licensee #1/Registered Nurse revealed: -A different pest control company had sprayed the facility since 4/5/18 and had a 90 day guarantee. -A follow up appointment would be done within the next week or so to ensure the facility no longer had bedbugs.	V 738		