Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL065-259	A. BUILDING: _____ B. WING _____	04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE FOREST ACADEMY DAY TREATMENT	1806 SOUTH 15TH STREET WILMINGTON, NC 28401

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on April 12, 2018. The complaint was unsubstantiated (intake #NC0013714). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1400 Day Treatment for Children and Adolescents with Emotional or Behavioral Disturbances.	V 000		
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: 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	V 132		

T. Lindsay Jones, Quality Improvement Dir. 5-4-18

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V 132	Continued From page 1 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 notify the Health Care Personnel Registry (HCPR) of allegations of abuse and neglect made against facility staff. The findings are: Review on 4/11/18, and 4/12/18 of client #49's IRIS reports dated 3/22/18 revealed: -Starting at 10 am on 3/22/18, client #49 had been placed in 7 physical restraints and in seclusion 3 times. -During the second seclusion client #49 "began yelling and crying while saying that his arm hurt" after putting his arm through the opening of the seclusion room door as he was trying to hit the staff. -Continued documentation read, "Client spoke with program director ... Client voiced that staff had hit him in the classroom and wouldn't allow him to complete his work and that is why he became aggressive."	V 132	Coastal Horizons Center (CHC) received a standard deficiency for failing to notify HCPR of allegations made against facility staff. G.S. 131E-256(G) HCPR-Notifications, Allegations, & Protection. In order to maintain compliance CHC will implement the following actions/policies: 1. All allegations of abuse by facility staff will be reported by the Program Director to HCPR & CPS in a timely manner – within 24 hours 2. Routine reviews of incidents will take place to insure accurate & timely reporting 3. Client Rights Committee (CRC) will review all incidents involving Restrictive Intervention. Program Director (PD) or designee will review all incidents involving allegations. 4. CRC will review all incidents on a monthly basis. PD will incidents as they occur. CRC reviews will commence as of 5/24/18. PD reviews will commence immediately.	

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V 132	Continued From page 2 Review on 4/12/18 of "Consumer Comment/Grievance Form" dated 3/29/18 and signed by client #49's mother read: "On Thurs. March 2nd [client #49] had some type of crisis during the crisis [client #49's] arm was slammed in the door leaving a 4 inch bruise on his forearm (right arm). I'm concerned with the lack of attention if any or concern about his injury." Review on 4/12/18 of the internal investigation summary by the facility Quality Improvement Director dated 4/3/18 revealed: -An investigation was done 4/2/18 of client #49's mother's allegations that her son had been injured during a restraint and staff did not seem concerned about his medical needs. -Staff involved in the incident demonstrated how the client could bruise their arm by the seclusion room door. -Staff were not identified in summary. -No documentation the allegations had been reported to the HCPR. There was no documentation client #49's allegation that he had been hit by staff on 3/22/18 had been investigated or reported to the HCPR. Interview on 4/12/18 the Interim Assistant Principal stated: -On 3/22/18 she saw client #49's arm come in contact with the seclusion room door and he said "you're hurting me." His arm hit the door as the door was opened when Qualified Professional #5 (QP #5) was trying to leave. At this point she left. There were no other staff in the seclusion room other than QP #5 when she left. Interview on 4/11/18 QP #5 stated: -3/22/18 IRIS report time 10 am was when client #49 was put into a physical restraint the first	V 132		

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V 132	Continued From page 3 time. These episodes lasted throughout the whole day. -He recalled client #49 got hurt by the seclusion room door. An administrator from the school had the client in a restraint and was trying to get out of the seclusion room. Client #49 said his arm was hurting while he is in seclusion room with the door shut. He said this a couple of times, then started banging on the door. He thought either the Therapist or Program Director evaluated client #49's arm at the end of the day. -He did not conduct the assessment of the client when he complained of arm pain. Interview on 4/12/18 client #49's mother stated: -She had made a complaint to the school following the restraint on 3/22/18. -She did not feel the staff intentionally hurt her son, but, they were neglectful in not identifying and acknowledging his injury and being more focused on how to prevent this from happening again in the future. Interview on 4/11/18 the Program Director stated: -Client #49's mother talked with the Program Director after she got to the emergency room on 3/22/18. -The mother was accusatory; very upset that he had a bruise, and thought it was as a result of something at the school. At some point, not sure when, mother said the staff caused the bruise. Interview on 1/12/18 the Quality Improvement Director stated: -He had completed the investigation of client #49's mother's allegation. -There had been no reports made to the HCPR, Department of Social Services, or as a Level 2 incident. -The complainant did not name a staff.	V 132		

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V 366	27G .0603 Incident Response Requirments 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 by:	V 366		

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V 366	Continued From page 5 (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 available within three months of the incident, the	V 366		

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V 366	Continued From page 6 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 review and interview, the facility failed to implement their written policy governing their response to level II incidents. The findings are: Review on 4/10/18 of client #49's record revealed: -8 year old male admitted 6/20/17. -Diagnoses included Other specified Disruptive, Impulse-Control, and Conduct Disorder, R/O Attention Deficit Hyperactive Disorder-combined presentation. Review on 4/11/18 and 4/12/18 of client #49's North Carolina Incident Response Improvement System (IRIS) level 2 report revealed:	V 366	CHC received a standard deficiency for failing to implement its written policy governing responses to L-II incidents. 10A NCAC 27G .0603 Incident Response Requirements for Category A and B Providers. In order to maintain compliance CHC will implement the following actions/policies: 1. On 5/8/18 all Coastal Horizons staff at Lake Forest Academy (LFA) will review CPI policy & procedures 2. The program director and on-site CPI instructor will be responsible for insuring those policies are implemented according to rule. 3. CRC will conduct monthly reviews to insure L-II policy & procedures are being appropriately implemented. 4. CRC will conduct reviews on a monthly basis starting on 5/24/18.	

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V 366	Continued From page 7 -Multiple restrictive interventions and seclusions used in response to client #49's aggressive behaviors. -Client #49 complained of pain in his arm during one of his seclusions. -No documentation the staff stopped and attended to the client's health and safety needs. -Incident prevention strategies did not include measures for injury prevention in a similar situation. -Client #49 told the Program Director he had been hit by staff and this had caused his behaviors. -There was no documentation client #49's allegation had been investigated.	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, 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;	V 367		

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V 367	Continued From page 8 (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 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	V 367		

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V 367	Continued From page 9 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 submit level II incident reports for allegations of abuse and neglect to the Local Management Entity (LME) within 72 hours of becoming aware of the incident. The findings are: Review on 4/10/18 of the North Carolina Incident Response Improvement System (IRIS) reports from 1/1/18 - 4/10/18 revealed there were no IRIS reports for allegations of abuse or neglect by facility staff. Review on 4/11/18, and 4/12/18 of client #49's IRIS reports dated 3/22/18 revealed: -Starting at 10 am on 3/22/18, client #49 had been placed in 7 physical restraints and in	V 367	CHC received a standard deficiency for failing to report L-II incident reports for allegations of abuse and neglect to the Local Management Entity (LME). 10A NCAC 27G .0604 Incident Response Requirements for Category A and B Providers. In order to maintain compliance CHC will implement the following actions/policies: 1. All allegations of abuse by facility staff will be reported by the Program Director or designee to the LME in a timely manner – within 24 hours 2. Routine reviews of incidents will take place to insure accurate & timely reporting 3. Client Rights Committee (CRC) will review all incidents involving Restrictive Intervention. Program Director (PD) will review all incidents involving allegations. 4. CRC will review all incidents on a monthly basis. PD will incidents as they occur. CRC reviews will commence as of 5/24/18. PD reviews will commence immediately.	

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V 367	Continued From page 10 seclusion 3 times. -Following client #49's second seclusion, "Client spoke with program director ... Client voiced that staff had hit him in the classroom and wouldn't allow him to complete his work and that is why he became aggressive." Review on 4/12/18 of "Consumer Comment/Grievance Form" dated 3/29/18 and signed by client #49's mother read: "On Thurs. March 2nd [client #49] had some type of crisis during the crisis [client #49's] arm was slammed in the door leaving a 4 inch bruise on his forearm (right arm). I'm concerned with the lack of attention if any or concern about his injury." Interview on 4/11/18 the Program Director stated: -Client #49's mother talked with the Program Director after she got to the emergency room on 3/22/18. -The mother was accusatory; very upset that he had a bruise, and thought it was as a result of something at the school. At some point, not sure when, mother said the staff caused the bruise. Refer to V132 for additional information.	V 367		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (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	V 500		

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V 500	Continued From page 11 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 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	V 500		

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V 500	Continued From page 12 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 notify the County Department of Social Services of allegations of abuse and neglect. The findings are: Review on 4/11/18 and 4/12/18 of client #49's Incident Response Improvement System (IRIS) report dated 3/22/18 revealed: -Client #49, "voiced that staff had hit him in the classroom and wouldn't allow him to complete his work and that is why he became aggressive." Review on 4/12/18 of "Consumer Comment/Grievance Form" dated 3/29/18 and signed by client #49's mother read: "On Thurs. March 2nd [client #49] had some type of crisis during the crisis [client #49's] arm was slammed in the door leaving a 4 inch bruise on his forearm (right arm). I'm concerned with the lack of attention if any or concern about his injury." Interview on 4/11/18 the Program Director stated: -Client #49's mother talked with the Program Director after she got to the emergency room on 3/22/18. -The mother was accusatory; very upset that he had a bruise, and thought it was as a result of	V 500	CHC received a standard deficiency for failing to notify the County DSS of allegations of neglect and abuse. 10A NCAC 27D .0101 Policy on Rights Restrictions and Interventions. In order to maintain compliance CHC will implement the following actions: 1. All allegations of abuse by facility staff will be reported by the Program Director or designee to the CPS in a timely manner – within 24 hours 2. Routine reviews of incidents will take place to insure accurate & timely reporting 3. Client Rights Committee (CRC) will review all incidents involving Restrictive Intervention. Program Director (PD) will review all incidents involving allegations. 4. CRC will review all incidents on a monthly basis. PD will incidents as they occur. CRC reviews will commence as of 5/24/18. PD reviews will commence immediately.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL065-259	A. BUILDING: _____ B. WING _____	04/12/2018

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V 500	Continued From page 13 something at the school. At some point, not sure when, mother said the staff caused the bruise. -No documentation the allegations had been reported to the County Department of Social Services. Refer to V132 and V367 for additional information.	V 500		
V 501	27D .0101(f) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (f) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policies which require that: (1) positive alternatives and less restrictive interventions are considered and are used whenever possible prior to the use of more restrictive interventions; and (2) consideration is given to the client's physical and psychological well-being before, during and after utilization of a restrictive intervention, including: (A) review of the client's health history or the comprehensive health assessment conducted upon admission to a facility. The health history or comprehensive health assessment shall include the identification of pre-existing medical conditions or any disabilities and limitations that would place the client at greater risk during the use of restrictive interventions; (B) continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of physical restraint throughout the duration of the restrictive intervention by staff who are physically present	V 501		

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V 501	Continued From page 14 and trained in the use of emergency safety interventions; (C) continuous monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being during the use of manual restraint; and (D) continued monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being for a minimum of 30 minutes subsequent to the termination of a restrictive intervention; and (3) following the utilization of a restrictive intervention, staff shall conduct debriefing and planning with the client and the legally responsible person, if applicable, as specified in 10A NCAC 27E .0104, to eliminate or reduce the probability of the future use of restrictive interventions. Debriefing and planning shall be conducted, as appropriate, to the level of cognitive functioning of the client. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide assessment and monitoring of a client's health, safety, and well-being continuously during restrictive interventions, and the client's physical and psychological well-being for a minimum of 30 minutes subsequent to the termination of a restrictive intervention, affecting 1 of 3 clients audited (#49). The findings are: Review on 4/11/18 of client #49's record revealed: -8 year old male admitted 6/20/17.	V 501	CHC received a standard deficiency for failing to provide assessment and monitoring of a client's health, safety, and well-being continuously during Restrictive Interventions (RI) and the client's physical and psychological well-being for a minimum of 30 minutes subsequent to the termination of a RI. 10A NCAC 27D .0101 Policy on Rights Restrictions and Interventions. In order to maintain compliance CHC will implement the following actions/policies: 1. For all uses of RI client's health, safety, and well-being will be monitored continuously and for 30 minutes subsequent to the termination of RI. 2. As part of CPI refresher training on 5/8/18 all LFA staff will review monitoring protocols & use of the monitoring form 3. The on-site CPI instructor and the PD or their designee will be responsible for insuring compliant monitoring occurs with all incidents of RI. 4. PD/their designee will review incidents upon completion. CRC will review incidents on a monthly basis.	

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V 501	Continued From page 15 -Diagnoses included Other specified Disruptive, Impulse-Control, and Conduct Disorder, R/O Attention Deficit Hyperactive Disorder-combined presentation. Review on 4/11/18 of client #49's North Carolina Incident Response Improvement System (IRIS) report dated 3/22/18 revealed: -On 3/22/18, during the second documented seclusion, client #49 "began yelling and crying, while saying that his arm hurt. Client sat in the corner of the seclusion room while repeating that arm hurt for a total of 15 seconds." Client #49 remained in seclusion for 7 minutes. -There was no documentation client was assessed for injury when he complained of arm pain. Review on 4/11/18 of client #49's IRIS report dated 3/19/18 revealed: -6 physical restraints and 2 seclusions. -The initial restraint occurred at 7:45 am. -No other times were documented for restrictive interventions or seclusions. -Client #49's restrictive interventions were terminated and he returned to the classroom 3 times during this day. -There was no documentation client #49's physical and psychological well-being was monitored for a minimum of 30 minutes prior to his returning to the classroom. Review on 4/11/18 of of client #49's IRIS report dated 3/12/18 revealed: -3 restrictive interventions and 2 seclusions. -The initial restraint occurred at 11 am. -No other times were documented for restrictive interventions or seclusions. -Client #49's restrictive interventions were terminated and he returned to the classroom	V 501		

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V 501	Continued From page 16 following the first seclusion. -There was no documentation client #49's physical and psychological well-being was monitored for a minimum of 30 minutes prior to his returning to the classroom. Interview on 4/11/18 Qualified Professional (QP) #5 stated: -3/22/18 IRIS report time 10 am was when client #49 was put into a physical restraint the first time. These episodes lasted throughout the whole day. -He recalled client #49 got hurt by the seclusion room door. Client #49 said his arm was hurting while he is in seclusion room with the door shut. He said this a couple of times, then started banging on the door. He thought either the Therapist or Program Director evaluated client #49's arm at the end of the day. -He did not conduct the assessment. Interview on 4/11/18 the Program Director and Therapist stated: -On 3/22/18 they became involved with client #49 around 1-1:30pm, after lunch. They both assessed the client and decided to do an involuntary commitment. -They did not hear the client complain of arm pain. -He was taken to the hospital around 3 pm. -Client #49's mother went to the emergency room after she was notified he was being involuntarily committed. From the emergency room the mother called and told the Program Director that client #49 had a bruise on his arm. Observation and interview on 4/12/18 at 12:12pm with client #49's mother's revealed: -Client #49's mother showed the surveyor a picture on her cell phone.	V 501		

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V 501	Continued From page 17 -The mother stated she had taken this photograph of client #49's arm while he was in the emergency room on 3/22/18. -Observations of the photograph revealed a picture of the forearm, palm up, with a dark area, consistent with a bruise, and vertical in shape. The area was centered between the wrist and elbow and covered approximately 1/3 the length of the child's forearm.	V 501		
V 521	27E .0104(e9) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (9) Whenever a restrictive intervention is utilized, documentation shall be made in the client record to include, at a minimum: (A) notation of the client's physical and psychological well-being; (B) notation of the frequency, intensity and duration of the behavior which led to the intervention, and any precipitating circumstance contributing to the onset of the behavior; (C) the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used; (D) a description of the intervention and the date, time and duration of its use; (E) a description of accompanying positive methods of intervention; (F) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion,	V 521		

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V 521	Continued From page 18 physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions; (G) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and (H) signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to document restrictive interventions as required to include, but not limited to, the time and duration of its use, debriefing, and planning, client's physical and psychological well-being, affecting 1 of 3 clients audited (client #49). The findings are: Review on 4/11/18 of client #49's record revealed: -8 year old male admitted 6/20/17. -Diagnoses included Other specified Disruptive, Impulse-Control, and Conduct Disorder, R/O Attention Deficit Hyperactive Disorder-combined presentation. -Behavior Plans with effective dates, 8/24/17 and 3/23/18, signed by client #49's mother/guardian giving consent for the use of restrictive interventions if needed. Finding #1: Review on 4/11/18 of the "DHHS Restrictive Intervention Details Report" report of restrictive interventions on 4/2/18 of client #49 revealed: -Intervention start time documented, 1:47 pm. -5 restrictive interventions were documented between the initial restrictive intervention in the	V 521	CHC received a standard deficiency for failing to document restrictive interventions as required to include, but not limited to, the time and duration of its use, debriefing, and planning, client's physical and psychological well-being. 10A NCAC 27E .0104 Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices used for behavioral control. In order to maintain compliance CHC will implement the following actions/policies: 1. LFA staff will document for all RI incidents the times, duration, staff and client debriefing, and client's physical &/psychological well-being 2. On 5/8/18 LFA staff will be trained on the use of forms for recording physical & psychological well-being 3. PD/their designee & CRC will be responsible for reviewing incidents to insure they are appropriately documented. 4. Incidents will be reviewed following the incident by PD/their designee and monthly by CRC	

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V 521	Continued From page 19 classroom and the last restrictive intervention in the "cool down" room prior to placing client #49 in seclusion. -Time and duration of each restrictive intervention was not documented. -Time client #49 was placed in seclusion was not documented. -Only 1 "initial," 1 "ending," and 1 "follow up" assessment of client #49's physical and psychological well-being was documented. The times of the assessment were not documented. Finding #2: Review on 4/11/18 of the North Carolina Incident Response Improvement System (IRIS) report dated 3/22/18 of restrictive interventions of client #49 revealed 7 restrictive interventions and 3 seclusions. Review on 4/12/18 of Client #49's 3/22/18 Daily Notes revealed no documentation time and duration for each restrictive intervention, seclusion, client's physical and psychological well-being, or debriefing. Finding#3: Review on 4/11/18 of the IRIS report dated 3/19/18 of restrictive interventions of client #49 revealed 6 physical restraints and 2 seclusions.. Review on 4/12/18 of Client #49's Daily Notes dated 3/19/18 revealed no documentation time and duration for each restrictive intervention, seclusion, client's physical and psychological well-being, or debriefing. Finding 4: Review on 4/11/18 of the IRIS report dated 3/12/18 of restrictive interventions of client #49 revealed 3 restrictive interventions and 2	V 521		

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V 521	Continued From page 20 seclusions. Review on 4/12/18 of Client #49's Daily Notes dated 3/12/18 revealed no documentation time and duration for each restrictive intervention, seclusion, client's physical and psychological well-being, or debriefing. Interview on 4/11/18 Qualified Professional #5 stated: -There were no debriefing meetings following restrictive interventions/episodes with staff. After an episode it was "over" for the QP and his day continued on without any huddle or debriefing meetings. -When he made a daily note he would include the restrictive interventions but there were no specific required elements to be included in his documentation. Interview on 4/11/18 the Program director stated: -Restrictive interventions were documented as level 1 incidents using the "DHHS Restrictive Intervention Details Report" if the client had a current behavior plan. -If there was no current behavior plan, the restrictive interventions were documented as Level 2 incidents in the IRIS system. -She had been told the restrictive intervention documentation could not be kept in the client's "regular" chart. -She maintained a folder for each client where she filed copies of the level 1 reports (DHHS Restrictive Intervention Details Reports). If the restrictive intervention was a level 2, only the face sheet of the IRIS report was printed and placed in the client incident folder. -There would be some documentation in the daily notes done by the qualified professionals.	V 521		

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V 521	Continued From page 21 Interview on 4/11/18 the Quality Improvement Director stated the facility documented "restraint episodes" that included all restrictive interventions until the aggressive behaviors ended.	V 521		
V 524	27E .0104(e12-16) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (12) The use of a restrictive intervention shall be discontinued immediately at any indication of risk to the client's health or safety or immediately after the client gains behavioral control. If the client is unable to gain behavioral control within the time frame specified in the authorization of the intervention, a new authorization must be obtained. (13) The written approval of the designee of the governing body shall be required when the original order for a restrictive intervention is renewed for up to a total of 24 hours in accordance with the limits specified in Item (E) of Subparagraph (e)(10) of this Rule. (14) Standing orders or PRN orders shall not be used to authorize the use of seclusion, physical restraint or isolation timeout. (15) The use of a restrictive intervention shall be considered a restriction of the client's rights as specified in G.S. 122C-62(b) or (d). The documentation requirements in this Rule shall satisfy the requirements specified in G.S. 122C-62(e) for rights restrictions. (16) When any restrictive intervention is utilized	V 524		

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V 524	Continued From page 22 for a client, notification of others shall occur as follows: (A) those to be notified as soon as possible but within 24 hours of the next working day, to include: (i) the treatment or habilitation team, or its designee, after each use of the intervention; and (ii) a designee of the governing body; and (B) the legally responsible person of a minor client or an incompetent adult client shall be notified immediately unless she/he has requested not to be notified. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to immediately discontinue the use of a restrictive intervention at any indication of risk to the client's health or safety, and immediately notify the legally responsible person of a minor client when a restrictive intervention is utilized, affecting 1 of 3 clients audited (#49). The findings are: Review on 4/11/18 of client #49's record revealed: -8 year old male admitted 6/20/17. -Diagnoses included Other specified Disruptive, Impulse-Control, and Conduct Disorder, R/O Attention Deficit Hyperactive Disorder-combined presentation. Review on 4/11/18 of the client #49's restrictive intervention report dated 3/22/18 revealed. -On 3/22/18, during the second documented seclusion, client #49 put his arm through a small opening of the seclusion room door in an attempt to hit the staff member on the other side. Client #49 "began yelling and crying while saying that his arm hurt. Client withdrew his arm from the opening at this time and sat in the corner of the	V 524	CHC received a standard deficiency for failing to immediately discontinue the use of a restrictive intervention at any indication of risk to the client's health or safety, and immediately notify the legally responsible person of a minor client when a restrictive intervention is utilized. 10A NCAC 27E .0104 Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices used for behavioral control. In order to maintain compliance CHC will implement the following actions/policies: 1. LFA staff will immediately discontinue use of RI when risk is present. 2. On 5/8/18 all LFA staff will receive a refresher training on risks associated with RI and appropriate responses to them. 3. PD/their designee will review all incidents to determine if staff responded appropriately to episodes of risk. 4. Risk review will occur immediately following episodes of RI	

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V 524	Continued From page 23 seclusion room while repeating that arm hurt for a total of 15 seconds." -Client #49 remained in seclusion for 7 minutes. -No documentation client was assessed for injury when he complained of arm pain. Interview on 4/11/18 Qualified Professional (QP) #5 stated: -3/22/18 IRIS report time 10 am was when client #49 was put into a physical restraint the first time. These episodes lasted throughout the whole day. -He recalled client #49 got hurt by the seclusion room door. Client #49 said his arm was hurting while he is in seclusion room with the door shut. He said this a couple of times, then started banging on the door. He thought either the Therapist or Program Director evaluated client #49's arm at the end of the day. -He did not conduct the assessment of the client when he complained of arm pain. Interview on 4/12/18 the Interim Assistant Principal stated: -On 3/22/18 she saw client #49's arm come in contact with the seclusion room door and he said "you're hurting me." -His arm was not caught in the door as it was being shut; his arm hit the door as the door was opened and QP #5 was trying to leave the seclusion room. There were no other staff in the seclusion room other than QP #5 when she left. At this point she left. Telephone interview on 4/10/18 client #49's mother stated: -On 3/22/18 the staff did not call her until 2:05pm. They usually contacted her if there was a problem. -She was told "it's been a really rough day with	V 524		

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V 524	Continued From page 24 [client #49]." He was in seclusion twice, calmed, returned to the classroom, and attacked the teacher. She questioned why they had not called her. -They told her client #49 was being involuntarily committed to the hospital. -Her son was still at the school when they called her. They asked her if she wanted to come to the school or meet him at the hospital. -No one mentioned his arm was bruised. Interview on 4/11/18 the Therapist stated: -Client #49's mother was called when she (Therapist) returned from the courthouse to initiate the involuntary commitment (IVC) of client #49. -When a client was admitted they talked to parents about being able to "take a breath" when their child was in the Day Treatment Program because they (Day Treatment Staff) would handle a crisis and let them know without making multiple calls. -She and the Program Director decided to IVC client #49 before calling the Mom. This was a "professional decision." As a clinician she felt client #49 needed to be seen by a physician because of his severe aggression, not only physically aggressive, but the intensity of his aggression. Client #49 seemed delusional, and to have a paranoid response. -She was concerned if she called client #49's mother first, she would have come and "rescued him" and he would not be seen by a physician. -Client #49 was in the seclusion room when they decided to do an IVC. He then came out of the seclusion room. -Client #49's mother notified the Program Director while in emergency room that her son had a bruise on his arm. -Client #49 was taken to the hospital around 3	V 524		

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	MHL065-259	A. BUILDING: _____ B. WING _____	04/12/2018

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V 524	Continued From page 25 pm.	V 524		
V 525	27E .0104(e17) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (17) The facility shall conduct reviews and reports on any and all use of restrictive interventions, including: (A) a regular review by a designee of the governing body, and review by the Client Rights Committee, in compliance with confidentiality rules as specified in 10A NCAC 28A; (B) an investigation of any unusual or possibly unwarranted patterns of utilization; and (C) documentation of the following shall be maintained on a log: (i) name of the client; (ii) name of the responsible professional; (iii) date of each intervention; (iv) time of each intervention; (v) type of intervention; (vi) duration of each intervention; (vii) reason for use of the intervention; (viii) positive and less restrictive alternatives that were used or that were considered but not used and why those alternatives were not used; (ix) debriefing and planning conducted with the client, legally responsible person, if applicable, and staff, as specified in Parts (e)(9)(F) and (G) of this Rule, to eliminate or reduce the probability of the future use of restrictive interventions; and (x) negative effects of the restrictive intervention, if any, on the physical and psychological	V 525		

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V 525	Continued From page 26 well-being of the client. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain documentation in a log of restrictive interventions to include all required information. The findings are: Review on 4/11/18 and 4/12/18 of the facility Incident Logs for March 2018 revealed: -Reports for restrictive interventions were included in the Incident Log with other incidents. -The log did not include Client #49's restrictive interventions on 3/6/18. -3/12/18 Incident Log read there were 2 restrictive interventions and 1 seclusion. (The North Carolina Incident Response Improvement System (IRIS) report documented 3 restrictive interventions and 2 seclusions.) -3/19/18 Incident Log read there were 2 restrictive interventions and 1 seclusion. (The IRIS dated 3/19/18 report documented 6 restrictive interventions and 2 seclusions.) -3/22/18 Incident Log read there were 2 restrictive interventions and 1 seclusion. (The IRIS dated 3/22/18 report documented 7 restrictive interventions and 3 seclusions.) -The log did not include the following required documentation: -time of each intervention -duration of each intervention -positive and less restrictive alternatives that were used or that were considered but not used and why those alternatives were not used -debriefing and planning conducted with the client, legally responsible person, and staff -negative effects of the restrictive intervention, if any, on the physical and psychological well-being of the client	V 525	CHC received a standard deficiency for failing to maintain documentation in a log of restrictive interventions to include all required information. 10A NCAC 27E .0104 Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices used for behavioral control. In order to maintain compliance CHC will implement the following actions/policies: 1. A log will be developed & implemented that includes: a. Start – Stop times b. Duration of RI c. Positive & less restrictive measures attempted d. Reasons for failure of less restrictive e. Debriefing f. Negative effects if any on client 2. LFA staff will receive training on the appropriate use of log 3. PD/their designee & CRC will be responsible for reviewing logs 4. Reviews will occur within 24 hours following the incident by PD/their designee & monthly by CRC	

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V 525	Continued From page 27 Interview on 4/11/18 Qualified Professional #5 stated there are no debriefing meetings following restrictive intervention/episodes with staff. After an episode and its "over" for the QP his day continued on without any huddle or debriefing meetings. Interview on 4/12/18 the Program Director stated restrictive interventions were included on the Incident Log; there was no separate log for reporting restrictive interventions.	V 525		
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	V 536		

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V 536	Continued From page 28 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 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:	V 536		

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V 536	Continued From page 29 (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 (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	V 536		

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V 536	Continued From page 30 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. This Rule is not met as evidenced by: Based on interviews, the facility failed to assure staff including service providers, employees, or volunteers, demonstrated competence by successfully completing training on alternatives to restrictive interventions annually. The findings are: Interview on 4/12/18 the Interim Assistant	V 536	CHC received a standard deficiency for failing to assure staff including service providers, employees, or volunteers, demonstrated competence by successfully completing training on alternatives to restrictive interventions annually. 10A NCAC 27E .0107 Training on Alternatives to Restrictive Interventions. In order to maintain compliance CHC will implement the following actions/policies: 1. All LFA staff will be trained in alternatives to RI before physically engaging with clients. Annual re-certs will occur to insure certifications are maintained. 2. Reviews of HR training records will occur to insure compliance 3. Quality Improvement Training Director (QITD) will be responsible for completing reviews of personnel records. 4. Record reviews will occur on a quarterly basis.	

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V 536	Continued From page 31 Principal stated: -She had been the Interim Assistant Principal since December 2017. -The principal had resigned and she had been recalled from retirement to help during this transition. -As the administrator she was there to support all of the staff. -On 3/22/18 she saw the situation with QP #5 and client #49 in the cool down room. Client #49 was being aggressive,"targeting" QP #5, hitting QP #5. She stepped in to support QP #5. She asked QP #5 to step out hoping this would calm Client #49. The paraprofessional, staff #6, stepped into the room when QP #5 stepped out. The client continued to be aggressive and she put him in a therapeutic hold and seclusion. -She did not have current CPI (Crisis Prevention Institute) certification. -She last took CPI in 2016. -Training was done annually for school staff. Interview on 4/12/18 the Program Director and Quality Improvement Director stated they were not aware the Interim Assistant Principal was not currently CPI certified.	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	V 537		

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V 537	Continued From page 32 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 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);	V 537		

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V 537	Continued From page 33 (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 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	V 537		

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V 537	Continued From page 34 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. (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	V 537		

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V 537	Continued From page 35 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 record reviews and interviews, the facility failed to assure staff including service providers, employees, or volunteers had been trained at least annually and demonstrated competence in the use of seclusion, physical restraint and isolation time-out prior to the use these interventions affecting 1 of 2 school staff interviewed (Interim Assistant Principal) and 1 of 3 staff audited (Qualified Professional #5). The findings are: Review on 4/11/18 of the client #49's North Carolina Incident Response Improvement System (IRIS) report dated 3/22/18 revealed: -On 3/22/18, client #49 was placed in 7 physical restraints and 3 seclusions. During the second seclusion, client #49 put his arm through a small opening of the seclusion room door in an attempt to hit the staff member on the other side. Client #49 "began yelling and crying while saying that his arm hurt. Client withdrew his arm from the opening at this time and sat in the corner of the seclusion room while repeating that arm hurt for a total of 15 seconds." Client #49 remained in	V 537	CHC received a standard deficiency for failing to assure staff including service providers, employees, or volunteers had been trained at least annually and demonstrated competence in the use of seclusion, physical restraint and isolation time-out prior to the use these interventions. 10A NCAC 27E .0108 Training in Seclusion, Physical Restraint, and Isolation Time-Out. In order to maintain compliance CHC will implement the following actions/policies: 1. All LFA staff will be trained in the use of seclusion, restraint, and isolation time-out before physically engaging with clients. Annual re-certs will occur to insure certifications are maintained. 2. Reviews of HR training records will occur to insure compliance 3. Quality Improvement Training Director (QITD) will be responsible for completing reviews of personnel records. 4. Record reviews will occur on a quarterly basis to insure certifications are valid	

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V 537	Continued From page 36 seclusion for 7 minutes. -There was no documentation client #49 was assessed for injury when he complained of arm pain. Interview on 4/12/18 the Interim Assistant Principal stated: -She did not have current CPI (Crisis Prevention Institute) certification. -She last took CPI in 2016. -She had been the Interim Assistant Principal since December 2017. -Restrictive interventions were primarily the job of the Day Treatment Staff. School staff may put a child in a restraint if the child was a danger to self or others. -As the administrator she was there to support all of the staff. -On 3/22/18 she saw the situation with QP #5 and client #49 in the cool down room. Client #49 was being aggressive,"targeting" QP #5, hitting QP #5. She stepped in to see what she could do to support QP #5. She asked QP #5 to step out hoping this would calm Client #49. The paraprofessional, staff #6, stepped into the room when QP #5 stepped out. She had to put client #49 in a therapeutic hold. While client #49 was in the hold and in front of her, she walked him into the seclusion room. Every time she released him in the seclusion room client #49 began hitting, biting, and attacking her. She had to reapply the restrictive interventions 3 times. After the 3rd time, QP #5 returned to the seclusion room. She told QP #5, "My goal is to get out and he (client #49) stay in." QP #5 assumed the restrictive intervention of client #49 in the back of the seclusion room for her to leave. QP #5 released client #49 and tried to leave the room. During this time she saw client #49's arm come in contact with the door and he said "you're hurting me." At	V 537		

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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 537	Continued From page 37 this point she left. His arm was not caught in the door as it was being shut; his arm hit the door as the door was opened and QP #5 was trying to leave. There were no other staff in the seclusion room other than QP #5 when she left. Review on 4/12/17 of QP #5's personnel record revealed: -Hire date of 7/3/17. -CPI certified 8/11/17. Interview on 4/12/18 QP#17/CPI Instructor stated: -He was the CPI Instructor for the Day Treatment Program. He did not provide training for the school staff. He thought the school system employed CPI instructors to train school staff. -Moving a child from the cool down room to the seclusion room would usually be done by 2 people using the limited control walk. Once inside the seclusion room, 1 staff would release while the other staff would continue a standing restraint. One staff may stay in the seclusion room or decide to leave for safety of the child or the staff. -If a child complained they were hurt during a restrictive intervention, one should release the child and assess the child. With all restraints there was a 30 minute observation time post restraint. During this time the client would be assessed. If the child complained of pain the supervisor should be notified immediately. Interview on 4/11/18 Qualified Professional (QP) #5 stated: -3/22/18 IRIS report time 10 am was when client #49 was put into a physical restraint the first time. These episodes lasted throughout the whole day. -He recalled client #49 got hurt by the seclusion room door. An administrator from the school had	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL065-259	A. BUILDING: _____ B. WING _____	04/12/2018

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V 537	Continued From page 38 the client in a restraint and was trying to get out of the seclusion room. Client #49 said his arm was hurting while he is in seclusion room with the door shut. He said this a couple of times, then started banging on the door. He thought either the Therapist or Program Director evaluated client #49's arm at the end of the day. -He did not conduct the assessment. Interview on 4/12/18 the Program Director and Quality Improvement Director stated they were not aware the Interim Assistant Principal was not currently CPI certified.	V 537		