

Appendix 1-B: Plan of Correction Form Date Survey Completed (C) 7-30-2018

Plan of Correction			
Please complete <u>all</u> requested information and mail completed Plan of Correction form to:		In lieu of mailing the form, you may e-mail the completed electronic form to:	
Provider Name:	Peace in the City 724 Thompson Rd Rutherfordton, NC 28139		Phone: 828-429-1811
Provider Contact Person for follow-up:	Michelle Lattimore Michelle Lattimore		Fax: 828-245-4447
Address:	724 Thompson Rd. Rutherfordton, NC 28139		Email: michellelattimore2000@yahoo.com
Provider # 828-429-1811			
Finding	Corrective Action Steps	Responsible Party	Time Line
<u>V000</u> INITIAL COMMENTS V 000 A complaint survey was completed on July 30, 2018. The complaints were substantiated (intake #NC00140140 and intake # NC00140838). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. <u>V 109 27G .0203 Privileging/Training Professionals</u> 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals.	DHSR - Mental Health AUG 23 2018 Lic. & Cert. Section	10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS	Implementation Date: 7-30-18 Projected Completion Date: Immediately and on going
An annual survey was			


 Michelle Lattimore
 B.D. Q.P.

(b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall	completed on 07-30-18. Deficiencies were cited for Type 1 A deficiencies This facility is licensed for the following services: 10 NCAC 27G.1700 - .0203 Residential Treatment Staff Secure for Children and Adolescents – Findings- During the site visit completed on 07/30/18, Type 1 A level deficiencies were cited . Peace in the City Inc. is a licensed facility for the provision of Residential Treatment Level III. Corrective Actions : Effective Immediately , Executive Director, Michelle Lattimore, BS, QP and Ann Chestnutt, BA, QP will go through 4 hours of continuation training along with other QP'S and AP's per month standards training. Effective Immediately. The Executive Director , Michelle Lattimore and Ann Chestnutt, Group Home Manager will facilitate an in-depth review of the service definition, policies, procedures and statutes governing the provision of Residential Treatment Level III services, including the rules pertaining to 10 NCAC 27G.-1700 Residential Treatment Staff Secure for Children and Adolescents . All administrative, clinical and direct support staff will be included in the in-depth review. Additional attention and focus will be directed to
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		the areas of the Type I-A deficiency cited during the site visit. Executive Director, and Group Home Manager will remain informed of changes or updates to standards, policies and procedures. Also, client specific training will be supported by Licensed Professional and CEO will take immediate steps to inform and train all staff related to standards, policies, procedures and changes to implement those practices in the provision of Residential Treatment Level III services.	
<u>Continued From page 1 V 109</u> develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record review and interviews, the facility's Qualified Professionals (QPs) failed to demonstrate knowledge, skills and abilities required by the population served for 2 of 2 QPs (QP #1/House Manager and QP #2/Executive Director). The findings are: Review on 7/3/18-7/6/18 of QP #1/House Manager (QP #1/HM)'s Personnel Record revealed: Date of Hire: 7/18/14 Job description revealed: -Position: Residential Treatment Qualified Professional/Residential House Manager; -QP duties: convene Child and Family Team	V109	Executive Director and Group Home Manager will receive Supervision per week by Licensed Professional to help ensure competencies of Executive Director and House Manager. See Exhibit (A)	Implementation Date: 7-30-18 Projected Completion Date: Immediately and ongoing

(CFT) meetings, coordinate the provision of multiple client services, develop and implement the client's Person Centered Plan (PCP), contribute to developing, updating and communicating goals, objectives, and discharge plans for individual clients, monitor the provision of services and supports, collaborate with other medical and treatment providers, provide basic care and supervision to clients in care, perform crisis and non-crisis intervention activities, and provide quality supervision, care and treatment for the clients.

Review on 7/3/18-7/6/18 of QP #2/Executive Director (QP #2/ED)'s job description revealed: -Position: Residential Treatment Qualified Professional/Executive Director; -QP Duties: Same duties as the aforementioned Residential Treatment Qualified Professional/Residential House Manager; -Training included: -5/20/17, Residential Treatment for Children and Adolescents-Section 1700; -5/20/17, Client Rights; -10/25/18, Seclusion, Physical Restraints and Isolation; -9/21/17, Standardized restraint prevention training program; -No client-specific training; -No clinical supervision contract or clinical supervision notes. Review on 7/9/18 of the QP #1/HM work schedule from 6/18/18-7/16/18 revealed: -Administrative hours worked was less than 10 hours a week (4:00-8:00 pm); -No administrative hours worked for week 6/18/18-6/24/18; -Worked 3rd shift the week on 6/23/18 (8:00 pm-8:00 am) and 7/2/18 (11:00 pm-8:00 am).	Implementation Date: 7-30-18 Projected Completion Date: Immediately and ongoing
V 109 Continued From page 3 V 109 Review on 7/6/18-7/12/18 of the facility's undated policies and procedures on restrictive interventions revealed: -Page 174, staff use of restrictive intervention	

would be "closely supervised by a qualified professional"; -Page 179 included the following statements about QP duties: -The Qualified Professional (QP) "must review the use of each restraint and must provide immediate feedback to the employee"; -The QP was responsible for notifying others "when restrictive interventions are used"; -Page 182 further contained the following information about QP duties under the heading titled "Restrictive Intervention": - "Whenever a restraint is utilized (each use of the intervention), the qualified professional will notify the following persons within 24 hours:" -the treatment team or designee; -a designee of the governing body; -the parent or legally responsible person of a minor client " ...will be notified immediately when such notification has been requested." Review on 7/10/18 of a county department of social services (DSS) case decision report dated 7/5/18 revealed: -DSS report received a Child Protective Services (CPS) report on 5/23/18 with allegations of emotional abuse and improper discipline by staff of a minor child; -The CPS findings were: -Multiple clients disclosed they were bullied and physically assaulted by other clients in the group home and staff did nothing about the client behaviors; -Former Client # 4 (FC #4) was 425 pounds in weight and was labeled by the clients as the "facility bully";			
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<u>V 109 Continued From page 4 V 109</u> -Former Client # 3 (FC #3) was hit by FC #4 with a clothes hanger while in a restraint; -FC #3 had been pinched by Client #1 multiple times until bruised; -Client #1 admitted to hitting FC #3 and tried to choke FC #3 while a staff drove the van; -The Qualified Professional #2/Executive Director and Chief Executive Officer (CEO) were "astonished" and were not aware of the aforementioned client situations; -DSS substantiated the finding of improper supervision of the clients by the facility staff. Review on 7/2/18 of the facility's incident reports revealed: -Requested facility incidents from 1/1/18 to 7/2/18 for review; -Incident reports reviewed for period 3/2018 through 6/2018; -No incident reports on Clients #1 and #2 and FC #3 and FC #4 for 1/2018-2/2018; -Refer to V367 for additional information on reviewed incident reports. Review on 7/3/18 of Client #1's record revealed: Date of admission: 5/23/18 Diagnoses: Oppositional Defiant Disorder (ODD), Attention-deficient Hyperactivity Disorder (ADHD) Combined Presentation Age: 10 History: Impulsive behaviors, an inability to perform in school due to disruptive, aggressive behaviors and unsafe behaviors that included running, anger outbursts, defiance and sexualized behaviors that resulted in school suspension and involvement of juvenile legal services, and a psychiatric hospitalization from 12/2017 to 1/2018 due to suicidal ideation/homicidal ideation (SI/HI) symptoms;		Implementation Date: 7-30-18 Completion Date: Immediately and ongoing Projected Completion Date: 7-30-18 Implementation Date: Immediately and ongoing
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-An admission assessment on Client #1 dated

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5/23/18 revealed:

-Struggled to implement learned skills of self-control and anger management and maintain reductions in symptoms and maladaptive behaviors;

-Client #1's Person-Centered Plan (PCP) dated 5/8/18 revealed:

-Client #1 was stepped up from Intensive In-Home Services to a Level III treatment program due to "serious deterioration" of interpersonal interactions that included the aforementioned behaviors in Client #1's history;

-Treatment goals were:

-Increased self-control and decreased SI/HI symptoms;

-Participation in medication management;

-Decreased aggressive behaviors and

increased ability to accept rejection from others;

-No updated treatment strategies that addressed Client #1's running and escalated aggressive behaviors toward peers and staff from 6/3/18-6/29/18;

-Refer to V112 on incidents of Client #1's escalated behaviors.

Review on 7/3/18 of FC #3's record revealed:

Date of admission: 5/25/17

Date of discharge: 6/15/18

Diagnoses: Oppositional Defiant Disorder (ODD),

Attention-deficient Hyperactivity Disorder

(ADHD),

Post-traumatic Stress Disorder (PTSD)

Age: 11

-History: Physical and verbal aggression of hitting, kicking, throwing objects at others, threatening to harm others, cursing, defiance of authority figures, non-compliance with rules, property destruction, and a partial residential treatment facility (PRTF) placement where behaviors continued and Client #1 was restrained for safety purposes;

<u>V 109 Continued From page 6 V 109</u> - An admission assessment on FC #3 dated in 5/2017 revealed: -Need for Level III placement to step down from PRTF care with decreased aggressive and defiant behaviors; - Person-Centered Treatment Plan (PCP) dated 3/8/18 on FC #3 revealed: -FC #3's Person-Centered Treatment Plan (PCP) dated 3/8/18 revealed: -Treatment goals were: -Reduced symptoms associated with PTSD; -Reduced symptoms associated with ADHD; -Reduced symptoms of ODD; -No updated treatment strategies that addressed FC #3's escalated behaviors from 1/2018-6/2018; -Refer to V112 on incidents of FC #3's escalated behaviors. Review on 7/3/18 of FC #4's record revealed: Date of admission: 3/14/18 Date of discharge: 6/15/18 Diagnoses: Unspecified Attention-deficient Hyperactivity Disorder (ADHD), Unspecified Trauma and Stressor-related Disorder, Oppositional Defiant Disorder (ODD) Age: 15 History: Physical and verbal aggressive behaviors included being argumentative, intentionally annoying, passive-aggressive and minimizing behaviors, bullying a younger sibling, oppositional defiant behaviors toward adults, elopement, multiple larceny charges from 10/2016-3/2018 with continued legal involvement, had Intensive In-Home Services and a Level III placement from 09/2017-12/2017; - An admission assessment on FC #4 dated 3/14/18 revealed: -Risk behaviors were violated curfew, stole cell phones and credit cards, and drove illegally; -Person-Centered Plan (PCP) updated 2/26/18		Implementation Date: 7-30-18 Projected Completion Date: Immediately and ongoing
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on FC #4 revealed:
- "Consistent severe" behavior issues for which FC #4 needed behavioral interventions to reduce aggressive and defiant behaviors and be stepped down to a lower level of care;
- Treatment goals:
- Express emotions and regulate behaviors appropriately;
- Identify emotions and communicate his needs effectively;
- Use learned anger management and coping skills;
- Decrease physical and verbal aggression and non-compliant behaviors;
- No updated treatment strategies that addressed FC #4's escalated behaviors in 6/2018 after his return to the facility from therapeutic leave from 5/25/18-5/28/18;
- Refer to V112 on incidents of FC #4's escalated behaviors.
Interview on 7/2/18 with Client #1 revealed:
- He had been at the facility for 2 months;
- He was there because he talked back to his parent;
- FC #3 started fights with him and other clients and then staff accused them of hurting him (FC #3);
- He argued with FC #3 because he and his peers were called bad names by FC #3;
- Stated that one time while on the van, FC #3 "started his stuff" and he (Client #1) took off his seatbelt and tried to choke FC #3;
- The staff who drove the van pulled over and FC #3 accused him (Client #1) of hitting him;
- Another staff who was on the van told FC #3 to stop it.
Interview on 7/2/18 with Client #2 revealed:
- He had been living at the facility since 8/2017;

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-He was placed because he had gotten into trouble with knives and had pushed a kid and broke the kid's rib;

-His was being discharged home in 8/2018 and he was too close to going home and was not messing up;

-FC #4 bullied him and his peers by telling them what to do "like he was staff", started arguments to get him and his peers to argue with each other, and had hit on him and his peers when staff were not looking and then say he did not do anything;

-Staff were in the room when FC #4 bullied and hit on them;

-Staff just didn't see it."

Interview on 7/3/18 with FC #3 revealed:

-He was admitted to his former placement about a year ago;

-He left his former placement because FC #4 hit him and he was not safe there;

-FC #4 had hit him on his back with a clothes hanger while he (FC #3) was restrained by staff on his bedroom floor for punching holes in the wall;

-Staff told FC #4 to stop hitting him and go away when FC #3 was restrained by staff;

-He was a little scared of FC #4 but FC #4 was a lot of talk;

-He had been restrained for punching holes in the walls and trying to harm himself;

-Staff thought he was running away one time because staff had chased and held him and then staff took him to his room.

Interview on 7/5/18 with FC #4 revealed:

-He lived at his former placement from March until June 2018;

-He had to leave because allegations were made against him that he hit on FC #3;

-He had physical fights with his peers that

included FC #3; -He denied hitting FC #3 with a clothes hanger while restrained and stated while staff had FC #3 restrained on the floor, staff asked him to remove a book under FC #3's stomach which he did; -Staff were impatient with him and his peers because the staff did not want to take the time to listen and staff would tell them to go to their rooms and stay. Interview on 7/3/18 and 7/9/18 with QP #1/HM revealed: -She became a Qualified Professional (QP) 2 years ago; -She worked as a QP and a House Manager at separate times; -She sometimes worked 3rd shift as one of two direct care staff; -She was the 3rd staff in the facility during her QP time; -She was the QP and House Manager for 2 other facilities under the licensee; -Her supervisor was the Qualified Professional #2/Executive Director (QP #2/ED); -She did not complete or update client treatment plans; -Her administrative time was spent as the Qualified Professional; -Her QP duties: -reviewed client treatment plans at client admission and when updated; -reviewed and signed off on daily client service notes by staff that were entered into the clients' treatment record; -ensured staff worked with the clients on their treatment goals; -started attending Child and Family Team (CFT) meetings; -worked directly with clients on coping with emotions, problem-solving, and communication			Implementation Date: 7-30-18 Projected Completion Date: Immediately and ongoing
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skills; -discussed client incidents with staff and notified the QP #2/ED of client incidents; -provided written client incident reports to the QP #2/Executive Director; -Was not aware of examples of written notes by staff in the 2018 staff communication notes: -1/30/18, a staff statement that FC #3 should be punished with room restriction for consequences of his aggressive behaviors; -6/2/18, Clients #1, #2 and FC #4 were left unsupervised while staff cleaned a bathroom; -6/8/18, Client #1 was restrained by staff on the couch for 1 hour; -4/26/18, FC #3 ran outside and laid down in the road; -QP #1/HM looked at the staff communication notes but did not review the notes in-depth; -There should have been incident reports completed by the staff on the aforementioned incidents; -She would review the staff communication notes closer and talk with staff; -She did some supervision of the direct care staff; -The Qualified Professional #2/Executive Director (QP #2/ED) and Chief Executive Officer (CEO) helped in the supervision of direct care staff; -FC #3 was upset and ran into the road about 1 week before he left the facility and was escorted by staff to his room but QP #2/HM was not aware if a written incident report had been completed by staff; -The QP #1/HM stated that if FC #3 had been restrained by staff on his bedroom floor, there would have been an incident report; -FC #4 would not have been in the room while FC #3 was restrained by staff because clients were told to go to their rooms when a client was restrained; -Physical restraint of a client involved holding		
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client's arms;
-"We don't do anything above the chest or take clients to the floor";
-There were written facility policies and procedures on client supervision and restrictive interventions that:
-Clients were to be continuously supervised by staff;
-Clients were restrained in emergency situations and when there were safety risks to the clients and/or staff:
-The staff who restrained a client was responsible for completing an incident report;
-Staff received facility policies and procedures during their employment orientation and "upper management" reviewed the policies with staff;
-Staff were trained on restraint use through a restraint prevention and use program;
-She could not recall if use of restrictive interventions were stated in the clients' treatment plans because they were used in emergency situations;
-A parent or legal guardian of a client was to be notified by the QP if a restraint was used on a client;
-"Room restriction" was used by staff for a client to have time to themselves in their room to reflect on their emotions and behaviors in instances where a client was upset or agitated, had fought with others or not listened to staff;
-Staff had the option to extend room restriction up to 48 hours if a client continued to be agitated or had done property destruction and needed extra time to themselves;
-Direct care staff decided on the use and duration of client room restriction;
-Observation checks on clients were done by staff every 15-30 minutes to ensure client safety;
-A client restricted to their room was not allowed

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but could come out of their room for meals, attend school and to use the bathroom;

-No incident reports were completed on client room restriction;

-A staff who placed a client in a physical restraint

was responsible for completing an incident report.

Interview on 7/2/18, 7/9/18, and 7/13/18 with the QP #2/ED revealed:

-She was a Qualified Professional and the Executive Director;

-Her QP duties included:

-the initial and updated client treatment plans;

-review of client daily service notes completed by staff;

-talked with clients at the facility or day program about their treatment progress and struggles;

-coordinated and linked clients to services

needed to support their treatment goals;

-worked with client families and linked the families to needed services;

-talked with client service providers and

obtained feedback on client treatment progress;

-facilitated CFT meetings and provided updates

on client progress and discussed client issues or concerns with the team;

-supervised the QP #1/House Manager (QP #1/HM) with the CEO;

-shared in supervision of the direct care staff with the QP #1/HM when needed;

-There was not an Associate Professional (AP) on

staff;

-She did not provide clinical supervision to staff because clinical supervision was the

responsibility of the Licensed Professional (LP);

-She was unable to locate Former Client #3's

daily client service notes from 3/1/18 to 5/11/18;

-The service notes were moved to an electronic

record system and FC #3's paper service notes

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electronic record;

-The QP #1/HM and direct care staff informed her

of client changes and incidents;

-She was aware there was 1 staff was on the van when FC #3 had taken a milk jug and hit the staff

who was driving the van;

-The other staff person was driving her own vehicle behind the van when this incident occurred and there was a written incident report;

-FC #3's behaviors escalated during his trauma-focused therapy and when FC #3's parent started participating in the therapy sessions;

-She had coordinated with the outpatient therapist

to provide FC #3 with trauma-focus therapy;

-FC #3 saw a peer discharged from the facility and struggled with the issue of not knowing what

his discharge plan looked like or a time frame for

discharge;

-It was the legal guardian's responsibility to keep FC #1 updated on his discharge plan and time frame for discharge;

-6/1/18-6/7/18, DSS investigated allegations that FC #3 was bullied and hit by FC #4 and allegation

of lack of client supervision by staff;

-There were no physical fights between the clients but clients may have touched one another on the shoulder;

-Staff deescalated client conflict by giving the clients "time out" in their rooms to calm down;

-Staff then talked with the clients in their room to process the conflict and what could have been done differently;

-"Room restriction" for the clients was the same as "time-out" and clients were only in their rooms

for maybe a few hours to a half a day;
-Client room restriction occurred no longer than a few hours;
-Room restriction was not specified in the client treatment plans;
-Staff were trained to use restraints on clients and

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restraints were used as a last resort;
-She was to be notified by staff whenever a client was restrained and to receive a written incident report on the client restraint;
-There were no Level II or Level III client incident reports from 1/2018 through 6/2018 because there were no client injuries beyond first aid and no police or medical emergency involvement;
-She had training in 12/2017 on the North Carolina Incident Response Improvement System (IRIS) and was familiar with the criteria to determine Level I, II, and III incidents.
Interview on 7/2/18 with the Chief Executive Officer (CEO) revealed:
-6/7/18, DSS made recommendations for increased supervision of the clients or have FC #3 and FC #4 separated and moved to different facilities;
-Since 6/7/18, there had been 2 staff meetings and the supervision policy and procedures were reviewed with staff and included QP #1/House Manager and QP #2/Executive Director;
-There were 2 staff working each of the 3 shifts;
-He looked at the liability of maintaining the placement for FC #3 and FC #4, determined both clients were not progressing in their services;
-"We had done all we could for them (FC #3 and FC #4)";
-At FC #3's 6/2018 CFT meeting, he recommended FC #3 be transitioned out to a Level IV because of FC #3's aggression, property

destruction, and the DSS concerns about supervision and safety;
-He wanted FC #4 to be in violation of his probation because of non-compliance with group home services;
-FC #3's guardian moved him out of the facility on 6/15/18 and into another placement;
-FC #4's was discharged back to his parent on

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6/15/18 with juvenile services assistance but FC #4 was caught stealing and was arrested.
Interview on 7/13/18 with Former Client #3 (FC #3)'s Outpatient Therapist revealed:
-He provided FC #3 and his parent with family therapy and not trauma-focused therapy;
-He was not aware and had not been consulted by staff that FC #3 had restrictive interventions;
-He wished there was more communication with facility staff.
Interview on 7/9/18 with FC #3's legal guardian revealed:
-He had monthly contacts with FC #3 and the staff in the facility and participated in FC #3's CFT meetings where he learned of FC #3' escalated behaviors of aggression;
-In a 4/2018 or 5/2018 CFT meeting, a discussion of FC #3's escalated behaviors included whether FC #3 needed a higher level of care;
-The QP #2/ED did not want FC #3 moved and wanted to continue working with him;
-FC#3's treatment goals and services were reviewed;
-No updated strategies were made in FC #3's plan to address FC #3's escalated behaviors;
-He was informed by staff that FC #3 was given space to calm down when the behaviors escalated and FC #3 was making progress in his treatment;
-He was not aware staff had physically restrained

FC #3;

-He observed during his 6/13/18 visit with FC #3 at the facility that 1 staff was present and then a 2nd staff arrived shortly after.

Interview on 7/3/18 with FC #4's juvenile service counselor revealed:

-FC #4 was placed at the facility in 5/2018

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because FC #4 had nowhere else to go;

-FC #4 had a history of bullying peers and bullied

his younger sibling in the home;

-FC #4 made threats to spank the younger clients at the facility and told staff he would take matters

into his own hands if they did not;

-FC #4 "did bad stuff to the kids when staff was not looking" (hitting and pinching) and then denied doing anything to the clients;

-She was made aware by staff that FC #4 hit one of the clients at the facility and she went to the facility and talked with FC #4 about his behaviors;

-Staff tried to re-direct FC #4 and he responded he would do what he wanted;

-FC #4 was discharged on 6/15/18 because it was unsafe for him to remain there with his behaviors toward the younger clients.

Interview on 7/2/18 with DSS that investigated the

CPS report allegations in 6/2018 revealed:

-She observed a bruise on one of FC #3's arms and FC #3 reported Client #1 had pinched him multiple times in the same spot on his arm;

-Client #2 reported he had a scar on his arm that was caused by FC #4 hitting him;

-FC #3 reported to another DSS social worker on discharge date of 6/15/18 that FC #4 hit him with

a hanger while he (FC #3) was restrained by staff;

-Client #1 was bullied by FC #4 and Client #1

bullied FC #3; -FC #4 "bragged" during her interview with him about hitting on the other clients; -All clients reported to her that staff did not do anything to stop the bullying behaviors; -She addressed the concerns with (QP #2/ED) and (CEO) and they seemed surprised to hear about the clients' bullying, pinching, and hitting behaviors; -On 6/7/18, the CEO's initial response was he would make other housing arrangements to <u>V 109 Continued From page 17 V 109</u> separate FC #3 and FC #4; -FC #3 and FC #4 were not separated prior to and not until both were discharged on 6/15/18. This deficiency is cross referenced into 10A NCAC 27G .1701 SCOPE (V293) for a Type A1 rule violation and must be corrected within 23 days. <u>V 112 Continued From page 18 V 112</u> This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to develop client strategies that deescalated out of control behaviors affecting 1 of 2 current clients (Client #1) and 2 of 2 former clients (FC #3 and FC #4). The findings are: Review on 7/6/18 of the facility's undated policy on Client Rights/Restrictive Interventions revealed: -Page 173, contained the following statements " ...does not utilize seclusion or isolation time out. However, when situations warrant it client would be asked to go to room." -Page 174, contained the following statements: -"Positive alternatives and less restrictive alternatives to restrictive interventions are to be		10A NCAC 27G..0205 An annual survey was completed on 07-30-18. Type I A Deficiencies were cited. This Rule was not met as evidenced by: Based on record review and interview conducted by Implementation Date: 7-30-18 Projected Completion Date: Immediately and ongoing
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considered and attempted whenever possible"; - "When the restrictive intervention is used on a recurring or planned basis, it will be incorporated into the treatment plan"; - Implementation of a restrictive intervention was to be "closely supervised by a QP"; - Page 180, a statement that whenever "restrictive interventions are used", documentation would be made in the client record. Review on 7/2/18 of a letter dated 6/15/18 from the Chief Executive Officer (CEO) to DSS revealed: - DSS recommended increased supervision of the clients due to allegations that clients were bullied - by a peer, a client had been hit by another peer with a clothes hanger and staff allowed the behaviors to continue; - Within 2 hours of the supervision request, the CEO met with the staff and increased the staff <u>V 112 Continued From page 19 V 112</u> from 2 to 3 in the facility; - The CEO stated " ...if we find that a client has bullied another peer in the home staff would have processed consequences; and implemented consequences for the behavior of the client whom is displaying the inappropriate behavior ..." Review on 7/3/18 of Client #1's record revealed: Date of admission: 5/23/18 Diagnoses: Oppositional Defiant Disorder (ODD), Attention-deficient Hyperactivity Disorder (ADHD) Combined Presentation Age: 10 History: Serious deterioration in impulsive behaviors, an inability to perform in school due	DHSR the facility failed to develop client strategies that deescalated out of control behaviors. This facility is licensed for the following services: 10 NCAC 27G.1700 - Residential Treatment Staff Secure for Children and Adolescents – Findings- During the site visit completed on 07/30/18, Type 1 A level deficiencies were cited . Peace in the City Inc. is a licensed facility for the provision of Residential Treatment Level III. Corrective Actions : Effective Immediately , Executive Director, Michelle Lattimore, BS, QP and Ann Chestnutt, BA, QP will support client with PCP Plan with interventions that's client specific. QP showing client presenting problems, client needs and strength based on client's specific needs. Also, linking and coordinating evaluations, assessments, such as psychiatric, substance abuse, medical, and vocational as appropriate to the client's needs.
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to disruptive, aggressive behaviors and unsafe behaviors that included running, anger outbursts, defiance and sexualized behaviors that resulted in school suspension and involvement of juvenile legal services, and a psychiatric hospitalization from 12/2017 to 1/2018 due to suicidal ideation/homicidal ideation (SI/HI) symptoms; -An admission assessment on Client #1 dated 5/23/18 revealed: -Struggled to implement learned skills of self-control and anger management and maintain reductions in symptoms and maladaptive behaviors; -Client #1's Person-Centered Plan (PCP) dated 5/18/18 revealed: -The prior treatment provider revised the PCP on 5/18/18 to change the level of care from Intensive In-Home Services to a Level III placement; -The Qualified Professional #2/Executive Director (QP #2/ED) had not updated the PCP; -Client #1's treatment goals were: -Increased self-control and decreased SI/HI symptoms; -Participate in medication management; <u>V 112 Continued From page 20 V 112</u> -Decreased aggressive behaviors and increased ability to accept rejection from others -No updated strategies in treatment plan that addressed Client #1's running and escalated aggressive behaviors toward peers and staff from 6/3/18-6/29/18; -No statement about use of restrictive interventions with Client #1 included in the treatment plan. Review on 7/3/18-7/12/18 of staff communication notes 6/3/18-7/2/18 that pertained to Client #1 revealed:	
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-The communication notes were not a part of the client treatment record and used by staff on each shift to communicate with one another about client incidents and facility operating issues; -6/3/18, Client #1 "had a bad fit fighting another client [Former Client #4]"; -6/5/18, argued with 2 peers at dining table, attempted to hit Former Client #3, staff intervened and escorted Client #1 to his room; -6/6/18, yelled, cursed, used profanity, was non-compliant with staff directions, "had to be escorted and restrained in his room by staff member then client ran out front door"; -Client #1 was chased, restrained, escorted to the facility van, and taken to school and day program by staff; -6/8/18, yelled, screamed, attempted to hit Former Client #4, and "had to restrain [Client #1] and hold him on couch 1 hr until he calmed down"; -6/10/18, verbally antagonistic toward his peers and was escorted to his room to calm down; -6/14/18, had a "tantrum" at 8:30 am and was with QP #2/ED at the church while staff took other clients to lunch and to the park; -There was an undated staff note entry between 6/14/18 and 2nd shift staff note dated 6/15/18 that		Projected Completion Date: Immediately and ongoing
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contained the following:

-At 9:30 am, Client #1 and Former Client #3 had a fight, were separated and restricted to their rooms with Client #1 redirected to stay in his room 3 times;

-Client #1 became upset about being blamed for a statement written with Client #1's marker on his and Client #2's wall;

-A staff statement "[QP #2/ED] asked that

[Client #1] be given a sandwich for lunch if he had bad behavior" and statement that Client #1 was fighting with a peer; -6/29/18, had a problem with listening and "had to be restrained after swinging on staff." Review on 7/3/18 of Former Client #3 (FC #3)'s record revealed: Date of admission: 5/25/17 Date of discharge: 6/15/18 Diagnoses: Oppositional Defiant Disorder (ODD), Attention-deficient Hyperactivity Disorder (ADHD), and Post-traumatic Stress Disorder (PTSD) Age: 11 History: Physical and verbal aggression of hitting, kicking, throwing objects at others, threatening to harm others, cursing, defiance of authority figures, non-compliance with rules, property destruction, and a partial residential treatment facility (PRTF) placement where behaviors continued and Client #1 was restrained for safety purposes; -An admission assessment on FC #3 dated in 5/2017 revealed: -Need for Level III placement as a step down from PRTF care with FC #3 having decreased aggressive and defiant behaviors; -Person-Centered Treatment Plan (PCP) dated 3/8/18 on FC #3 revealed: -Treatment goals were: -Reduced symptoms associated with PTSD; <u>V 112 Continued From page 22 V 112</u> -Reduced symptoms associated with ADHD; -Reduced symptoms of ODD; -A statement that staff was to provide one-on-one intervention as needed to assist FC #3 to meet his PCP goals in reduction of ODD,	
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ADHD and PTSD symptoms; -No clarification of what one-on-one intervention meant; -A statement that restrictive interventions may be used if warranted to ensure the client's safety and safety of others; -No clarification about the type(s) of and circumstances restrictive interventions would be permitted by staff to use with FC #3; -Contained a crisis plan that staff was to contact 911 if FC #3 harmed self or others and required immediate police involvement or medical care; -No updated treatment strategies that addressed FC #3's escalated behaviors from 1/2018-6/2018. Review on 7/3/18-7/12/18 of staff communication notes on FC #3 from 1/30/18 to 6/15/18 revealed: - The communication notes were not a part of the client treatment record and used by staff on each shift to communicate with one another about client incidents and facility operating issues; -1/30/18, an attempted physical assault on a peer with a fork; -Included a staff statement "Don't know if you put young boys on room restriction but definitely needs punished! for his consequences and behavior"; -2/1/18, verbally threatened to harm a staff with pencils, chairs and toys; -Included a staff statement "[QP #2/ED] said 3 more days of room restriction"; -3/19/18 and 3/30/18, threw a chair, linen and earplugs at staff and threw food at a peer; -4/7/18-4/19/18, assaulted a staff in the stomach, <u>V 112 Continued From page 23 V 112</u> attempted assault on a staff with a toy and attempted to stab a peer with a fork, verbal aggression toward a peer, and incidents of	
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arguing and fighting with a peer; -4/26/18, ran outside the facility and into the road, was chased by and returned to the facility by staff; -5/3/18, assaulted a direct care staff (Staff #3) who was driving the facility van by throwing a milk jug that also hit a peer in the front passenger seat beside Staff #3; -FC #3 was restrained by Staff #3 upon return to the facility for kicking Staff #3; -5/6/18, attempted to strike at a staff and was placed in a therapeutic hold by the staff, and assaulted a staff with a toy and caused bruising to the staff's arm; -5/12/18, used profanity at staff and peers, argued with peers, created further damage to his bedroom door by kicking, was left alone in his room to calm down, and continued hitting the door and walls; -5/18/18, cursed and threatened staff statement " ... other than that, no major incidents"; -5/22/18, tore blind off bedroom window, attempted to physically harm staff with pieces broken from the window blind, and staff was instructed by QP #2/ED to "restrain" FC #3 if needed and place him on the van for school; -5/31/18, refused to shower and to come out of his room, slammed his door and cursed at staff with staff comment "Bad kid"; -6/3/18, kicked and broke his bedroom door and fought with a peer; -6/5/18, argued with 2 peers at dining table and 1 peer attempted to hit FC #3; -6/6/18, statement that FC #3 was "very aggressive" and was assisted by staff back to his room; -6/14/18, fought with a peer and were separated		<u>V 112 Continued From page 24 V 112</u> by staff with FC #3 and the peer "restricted to room."
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Review on 7/12/18 of FC #3's daily service notes from 5/12/18-6/15/18 revealed:

- The daily service notes were completed by staff about client service progress and were part of FC #3's treatment record;

- 5/24/18, prompted by staff to cease bullying behaviors toward a peer, engaged in property destruction at the facility by flipping over a mattress and hitting the walls with staff verbal prompts to cease behaviors;

- FC #3 was monitored by staff to determine if "physical therapeutic intervention was necessary";

- 5/25/18, verbal altercation with peer with staff prompt for FC #3 to refrain from the altercation and was escorted by staff away from the situation

- with the peer;

- 5/29/18 and 6/2/18, verbally aggressive with a peer and staff attempted to redirect FC #3;

- 6/10/18, antagonized a peer, followed by a staff prompt not to stand in doorway of a peer, and FC

- #3 used profanity at staff;

- 6/15/18, used profanity in front yard with peers, staff prompted FC #3 to cease profanity and "horse-playing" with peers and to keep hands to self;

- FC #3 ceased use of profanity and ignored staff to cease from "horse-playing";

- Staff "stood between client and peer as a human barrier to prevent any action";

- Daily client service notes completed by staff and

- signed by one of two Qualified Professionals (Qualified Professional #1/House Manager or QP #2/ED).

Review on 7/3/18 of Former Client #4 (FC #4)'s record revealed:

Date of admission: 3/14/18

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Date of discharge: 6/15/18 Diagnoses: Unspecified Attention-deficient Hyperactivity Disorder (ADHD), Unspecified Trauma and Stressor-related Disorder, Oppositional Defiant Disorder (ODD) Age: 15 History: Physical and verbal aggressive behaviors included being argumentative, intentionally annoying, passive-aggressive and minimizing behaviors, bullying a younger sibling, oppositional defiant behaviors toward adults, elopement, multiple larceny charges from 10/2016-3/2018 with continued legal involvement; -An admission assessment on FC #4 dated 3/14/18 revealed: -Risk behaviors were violated curfew, stole cell phones and credit cards, and drove illegally; -Person-Centered Plan (PCP) updated 2/26/18 on FC #4 revealed: "Consistent severe" behavior issues for which FC #4 needed behavioral interventions to reduce aggressive and defiant behaviors and be stepped down to a lower level of care; -FC #4's treatment goals were: -Express emotions and regulate behaviors appropriately; -Identify emotions and communicate his needs effectively; -Use learned anger management and coping skills; -Decrease physical and verbal aggression and non-compliant behaviors; -No updated treatment strategies that addressed FC #4's bullying behaviors that escalated on 6/2/18 and after his therapeutic leave from 5/25/18-5/28/18. Review on 7/3/18-7/13/18 of staff communication notes pertaining to FC #4 from 5/15/18 to 6/15/18 revealed:			
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-The staff notes were not a part of FC #4's treatment record and included:
-5/15/18, fought with a peer on the facility van;
-6/1/18, initiated an argument with 2 peers and refused re-direction by staff;
-Included a staff statement "[FC #4] constantly lied about what he was doing to others even after being observed in the act";
-6/2/18, pinched Client #1 with Client #2's complaint to staff that FC #4 was picking on Client #1 and FC #3, and FC #4 denied any wrong doing;
-Included a staff statement "Staff did not see the situation due to staff cleaning the bathroom";
-6/5/18, argued with Client #1 and FC #3;
-Included a staff statement that "[FC #4] instigates with other clients, cursing at them and getting them arguing with each other, cursing and ready to fight" and "Getting out of control!"
Review on 7/12/18 of FC #4's daily service notes by staff revealed:
-The daily service notes were completed by staff about client service progress and made a part of FC #4's treatment record;
-FC #4's daily client service notes by staff from 4/1/18 to 6/3/18 revealed:
-4/2018, FC #4 utilized his "social graces", was courteous, exhibited proper conduct, showed a positive attitude in interactions with peers and staff;
-5/2018, FC #4's behaviors included an instigated verbal altercation with a peer and shoved a peer over van seating, stood in bedroom doorway of same peer and struck door causing property damage, threatened to stab a staff, and walked out of the facility to "walk off the premises";
-6/2018, FC #4 behaviors included separations from a peer to de-escalate conflict, respectful

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behaviors toward peers and staff, and ability to regulate his behaviors;

- Staff interventions included prompts to disengage from peer conflicts and mediation between FC #4 and peers to resolve conflicts;

- Daily client service notes were completed by staff and signed by one of two Qualified Professionals (QP #1/House Manager or QP #2/ED).

Interview on 7/2/18 with Client #1 revealed:

- FC #3 started fights with him and other clients were then accused of hurting FC #3;

- He argued with FC #3 because he and his peers were called bad names by FC #3;

- Stated that one time while on the van, FC #3 "started his stuff" and he (Client #1) took off his seatbelt and tried to choke FC #3;

- The staff who drove the van pulled over and FC #3 accused him (Client #1) of hitting him;

- Another staff who was on the van told FC #3 to stop it;

- He denied he had been restrained or held by staff so he could not move;

- He denied he had tried to run away;

- Staff stopped fights by telling him and his peers to quit fighting and go to their rooms;

- There was always 2 staff at the facility on each shift.

Interview on 7/2/18 with Client #2 revealed:

- FC #4 bullied him and his peers by telling them what do "like he was staff", started arguments to get him and his peers to argue with each other"

- FC #4 had hit on him and his peers when staff were not looking and then FC #4 said he did not do anything;

- Staff were in the room when FC #4 bullied and hit on them;

- "Staff just didn't see it";

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Implementation Date: 7-30-18 Projected Completion Date: Immediately and ongoing	-Stated that there were always 2 staff at the home. Interview on 7/3/18 with FC #3 revealed: -He did not have a one-on-one worker at his previous placement; -A therapist came to the facility and talked to him and his peers; -The therapist told him to tell staff when he was mad and not to punch the wall; -FC #3 stated it was better to punch a wall than a person; -Staff thought he was running away one time and had chased, held him and staff took him to his room; -Denied he laid down in the road outside the facility; -He was restrained by staff for punching holes in the walls and trying to harm himself; -He was a little scared of FC #4; -FC #4 had hit him on his back with a clothes hanger while he (FC #3) was restrained by staff on his bedroom floor for punching holes in the wall; -Staff told FC #4 to stop hitting him and go away when FC #3 was restrained by staff; -Former peers antagonized him and staff told him and his peers to quit fighting; -Staff stood between him and FC #4 when they fought and both were told to go to their rooms; -2 staff were always at the facility from the time he woke up and went to bed at night; -FC #3 had difficulty recalling approximate dates or times when the aforementioned incidents occurred. Interview on 7/9/18 with FC #3's legal guardian revealed: -He had monthly contacts with FC #3 in the facility and participated in FC #3's CFT meetings V 112 Continued From page 29 V 112
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where he learned of FC #3's escalated behaviors of aggression; -In a 4/2018 or 5/2018 CFT meeting, a discussion of FC #3's escalated behaviors included whether FC #3 needed a higher level of care; -The QP #2/ED did not want FC #3 moved and wanted to continue working with him; -FC#3's treatment goals and services were reviewed; -No updated strategies were made in FC #3's plan to address FC #3's escalated behaviors; -He was informed by staff that FC #3 was given space to calm down when the behaviors escalated and FC #3 was making progress in his treatment; -In a 6/2018 CFT meeting, group home staff, the Licensed Professional (LP) and principle of the day treatment program reported FC #3 agitated other peers, continued property destruction and needed a higher level of care; -During the time the 6/2018 CFT was held, there was a DSS investigation that FC #3 was hit by a peer and a possible lack of client supervision by staff; -He was not aware staff had physically restrained FC #3. Interview on 7/5/18 with FC #4 revealed: -He left the facility because of allegations against him that he hit on FC #3; -He had physical fights with his peers that included FC #3; -He physically pushed his peers away from him when they called him the "n-word"; -Staff responded by laughing when he pushed his peers away; -Staff were impatient with him and his peers because the staff did not want to take the time to listen and staff would tell them to go to their rooms and stay;		
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<u>V 112 Continued From page 30 V 112</u> -He denied hitting FC #3 with a coat hanger while FC #3 was restrained; -Stated he was asked by staff to remove a book from under FC #3's stomach during the restraint; -FC #4 stated he walked out of the facility one time without staff permission because he needed time alone; -2 staff were at the facility whenever the clients were there. Interview on 7/3/18 with FC #4's juvenile service counselor revealed: -She placed FC #4 at the facility because he had no other place to go; -FC #4 had a history of bullying peers and bullied a younger sibling in the home; -FC #4 made threats to spank the younger clients at the facility and told staff he would take matters into his own hands if they did not; -FC #4 "did bad stuff to the kids when staff was not looking" (hitting and pinching) and then denied doing anything to the clients; -She was made aware by staff that FC #4 hit one of the clients at the facility and she went to the facility and talked with FC #4 about his behaviors; -Staff tried to re-direct FC #4 and he responded he would do what he wanted; -FC #4 was discharged on 6/15/18 because it was unsafe for him to remain there with his behaviors toward the younger clients. Interview on 7/2/18 with Staff #1 revealed: -She had been a direct care staff at the facility for 2 years; -She worked 2nd shift with other staff; -An additional staff was placed on shift right before FC #3 and FC #4 were discharged; -She was familiar with the clients' diagnoses and behaviors;		Implementation Date: 7-30-18 Projected Completion Date: Immediately and ongoing
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-FC #3 fought with other clients and made holes

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in the walls by punching and kicking;
-Sometimes FC #3 had to be restrained by staff;
-She had not restrained FC #3 but FC #3 was placed on room restriction after he hit her in the stomach and tried to stab her with a toy a few months ago;
-No incident report was completed because FC #3 had calmed down;
-Her intervention with FC #3 when he was angry was to show FC #3 pictures of kittens and remind him to breathe to calm down;
-FC #3's moods changed in an instant so staff had to keep a "watch" on him;
-FC #4 was not physically aggressive but agitated the other clients to argue and fight;
-Client #1 was a good kid and liked to play outside like a 10 year old.
Interview on 7/2/18 with Staff # 2 revealed:
-He was a direct care staff and had returned to work in 4/2018;
-He rotated working 2nd and 3rd shifts and worked with other staff on his shifts;
-Client #2 and FC #3 had been at the facility the longest and was more familiar with their behaviors;
-Anything FC #3 did not like would set off FC#3's anger which resulted in FC #3 cursing, not listening to staff, attempting assault on staff, and punching and kicking the doors and walls;
-His intervention was to give FC #3 time to himself to calm down when angry;
-He had not restrained any of the clients;
-He never saw physical altercations or bullying behaviors between the clients.
Interview on 7/2/18 with Staff # 3 revealed:
-He was a direct care staff and had worked at the facility since 2/2018;
-He worked 2nd shift;

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-He was familiar with the clients' diagnoses and behaviors;
-FC #3 became physically aggressive over the slightest thing or when he did not get his way;
-FC #3's behaviors included punching holes in walls and throwing large items at people like chairs;
-5/3/18, While being transported, FC #3 had gotten a gallon of milk from the house groceries in back of the van, threw the milk jug from the van's back seat and hit him (Staff #3) in the back of the head which then hit the client seated in the front passenger seat;
-FC #3's behavior almost caused a vehicle accident;
-No other staff was on the van during the transportation;
-He placed FC #3 in a therapeutic hold when they got out of the van at the facility because FC #3 began kicking him;
-FC #3 calmed down when he was restrained but still cursed;
-He completed an incident report on the 5/3/18 incident;
-FC #4 liked to trigger the other clients to argue for entertainment;
-He instructed FC #4 more than once to stop irritating his peers or go to his room;
-Client #1 had explosive outbursts with yelling and screaming and tried to fight with other clients;
-He had been trained in an approved restraint use and prevention program.
Interview on 7/3/18 and 7/9/18 with the QP #1/HM revealed:
-She worked as a QP and a House Manager at separate times;
-She, QP #2/ED and the CEO supervised the

direct care staff; -She was the 3rd staff at the facility when there					<u>V 112 Continued From page 33 V 112</u> were 2 direct care staff on duty; -She did not complete or update client treatment plans; -Was not aware of the following examples of written staff notes in the 2018 staff communication notes: -4/26/18, FC #3 had ran outside and into the road; -6/1/18, Clients #1 and #2 and FC #3 and #4 were left unsupervised by staff because staff were cleaning the bathroom; -6/8/18, Client #1 had been held down on the couch by staff for 1 hour; -QP #1/HM stated that she looked at the staff communication notes but not in-depth; -There should have been incident reports by staff on the examples given; -She would review the communication closer and talk with staff; -Restraints were used on clients in emergencies where there were safety risks to the client and/or staff; -"We don't do anything above the chest or take clients to the floor"; -She could not recall if the use of restrictive interventions were stated in the clients' treatment plans; -"Room restriction" was used by staff for a client to have time to themselves in their room to calm down when agitated or upset; -Direct care staff decided on the use and duration of client room restriction with clients; -Staff could extend room restriction for a client up to 48 hours if the client continued to be agitated or had done property destruction and needed extra time to themselves;
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-No incident reports were completed on client room restriction;
-A staff who placed a client a physical restraint was responsible for completing an incident report;

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-She did not why staff had not completed incident reports when clients were restrained.
Interview on 7/9/18 with the Licensed Professional (LP) revealed:
-He had worked as the LP at the facility since 9/2017;
-He provided individual and group therapy to the clients;
-Reviewed the clients' treatment plans and progress notes;
-Was not responsible for writing or updating client treatment plans;
-Provided feedback on client issues and client therapy progress to the QP #2/ED when asked;
-Provided the clinical supervision to the QP#1/HM and direct care staff and made staff aware what each client was working so staff could learn techniques and continue working with the clients toward behavioral changes;
-He worked with FC #3 on verbalizing feelings (upset or angry) with staff and he worked with staff to provide FC #3 praise when he verbalized feelings instead using hitting, kicking, and punching behaviors;
-FC #4 had boundary issues and was the "junior staff person" who liked to tell his peers to go to their rooms when they were upset or angry but FC #4 had anger and low self-esteem issues himself;
-He worked with FC #4 on boundaries and recommended staff re-direct FC #4 to self-calming activities of reading and listening to music when angry or upset;

-The LP understood client room-restriction was "self-imposed" by the clients when they were angry or upset and needed to calm down;
-He stated that room restriction was a form of a restrictive intervention;
-He had not seen or heard about any of the

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clients being placed in restraints or therapeutic holds;
-The QP #2/ED had the documentation on his clinical time with the clients and staff.
Interview on 7/2/18-7/13/18 with the QP #2/ED revealed:
-She was a Qualified Professional and the Executive Director;
-She wrote initial and updated client treatment plans;
-She did not provide clinical supervision to staff because clinical supervision was the responsibility of the LP;
-She was unable to locate Former Client #3's daily client service notes from 3/1/18 to 5/1/18;
-The service notes were moved to an electronic record system and FC #3's paper service notes prior to 5/12/18 were not scanned into the electronic record;
-The QP #1/HM and direct care staff informed her of client changes and incidents;
-She had coordinated with the outpatient therapist to provide FC #3 with trauma-focus therapy and not family therapy;
-6/1/18-6/7/18, DSS had investigated allegations that FC #3 was bullied and hit by FC #4 and an allegation about a lack of client supervision by staff which resulted in DSS' recommendation of more client supervision by the facility;
-There were no physical fights between the clients but clients may have touched one another

on the shoulder; -Staff deescalated client conflict by giving the clients "time out" in their rooms to calm down; -Staff were then expected to talk with the clients in their room to process the conflict and what could have been done differently; -"Room restriction" for the clients was "time-out" and clients were only in their rooms for a few		
<u>V 112 Continued From page 36 V 112</u> hours to a half a day and no longer; -Staff were trained to use restraints on clients and restraints were used as a last resort; -1 staff usually was involved in restraining a client while the 2nd staff member supervised the other clients; -There should be an incident report any time a client is placed in a hold; -Staff were expected to call her and inform her if a client was restrained so she could find out the reason for the restraint; -There were no Level II or Level III client incident reports from 1/2018 through 6/2018 because there were no client injuries beyond first aid and no police or medical emergency involvement; -Incident reports were not completed by staff when clients were placed on room restriction because it was only for a "brief time" for clients to deescalate; -She had training in 12/2017 on the North Carolina Incident Response Improvement System (IRIS) and was familiar with the criteria to determine Level I, II, and III incidents. Interview on 7/13/18 with Former Client #3 (FC #3)'s Outpatient Therapist revealed: -He provided FC #3 with family therapy; -He had not provided FC #3 with trauma-		

focused therapy;
 -He did not make recommendations to staff as part of FC #3's treatment plan;
 -He was not aware that FC #3 had any restrictive interventions that included room restriction or was placed in therapeutic holds;
 -Room restriction for FC #3 would not have had a traumatic effect on FC #3 if staff gave a clear time frame for how long the room restriction would last;
 -FC #3 had a poor concept of time and not giving FC #3 a clear time period would have been a

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source of frustration for him;
 -He would have recommended against therapeutic holds on FC #3 because he had heard FC #3 had been injured during a restraint at his prior placement.
 This deficiency is cross referenced into 10A NCAC 27G .1701 SCOPE (V293) for a Type A1 rule violation and must be corrected within 23 days.
 V 293 27G .1701 Residential Tx. Child/Adol - Scope
 10A NCAC 27G .1701 SCOPE
 (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach.
 It shall not be the primary residence of an individual who is not a client of the facility.
 (b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of

this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to a community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: <u>V 293 Continued From page 38 V 293</u> (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure intensive and active therapeutic treatment and interventions and failed to design strategies that included individualized client		Implementation Date: 7-30-18 Projected Completion Date: Immediately and ongoing
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supervision, ensured client safety, and deescalated out-of-control behaviors affecting 1 of 2 current clients (Client #1) and 2 of 2 former clients (Former Client #3 and Former Client #4). The findings are: CROSS REFERENCE: 10A NCAC 27G .0203 Competencies of Qualified Professionals and	<u>V 293 Continued From page 39 V 293</u> Associate Professionals (V109) Based on record review and interviews, the facility's Qualified Professionals (QPs) failed to demonstrate knowledge, skills and abilities required by the population served for 2 of 2 QPs (QP #1/House Manager and QP #2/Executive Director) CROSS REFERENCE: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112) Based on record review and interviews, the facility failed to develop client strategies that deescalated out of control behaviors affecting 1 of 2 current clients (Client #1) and 2 of 2 former clients (FC #3 and FC #4) CROSS REFERENCE: 10A NCAC 27G .1702 Requirements of Qualified Professionals (V294) Based on record review and interview, the facility failed to ensure that 70% of the clinical and administrative responsibilities performed by the Qualified Professional (QP) occurred in the facility when children and adolescents were awake and present in the home. CROSS REFERENCE: 10A NCAC 27G .1703 Requirements for Associate Professionals (V295) Based on record review and interview, the facility failed to have at least one direct care staff who met the requirements of an Associate Professional (AP) and was responsible for the supervision of the direct care staff's
	<u>This Rule is not met as evidenced by:</u> Based on record review and interview, the facility failed to ensure intensive and active therapeutic treatment and interventions and failed to design strategies that included individualized client supervision, ensured client safety, and deescalated out-of-control behaviors the facility's Qualified Professionals (QPs) failed to demonstrate knowledge, skills and abilities required by the population served Assessment and Treatment/Habilitation or Service Plan (V112) Based on record review and interviews, the facility failed to develop client strategies that deescalated out of control behaviors. Requirements of Qualified Professionals (V294) Based on record review and interview, the facility failed to ensure that 70% of the clinical and administrative
Implementation Date: 7-30-18 Completion Date: Immediately and ongoing	

implementation of each child's treatment plan and participated in service planning meetings. CROSS REFERENCE: 10A NCAC 27G .1705 Requirements of Licensed Professionals (V297)Based on record review and interview, the facility failed to ensure the clinical consultation of the Qualified Professionals (QPs) and individual and group therapy services by the Licensed <u>V 293 Continued From page 40 V 293</u> Professional (LP) at least four hours per week CROSS REFERENCE: 10A NCAC 27G .0603 Incident Response Requirements for Category A and B Providers (V366) Based on record review and interview, the facility failed to implement their written policy regarding their response to incidents and failed to track client behaviors CROSS REFERENCE: 10A NCAC 27G .0604 Incident Response Reporting Requirements for Category A and B Providers (V367) Based on interview and record review, the facility failed to report Level II incidents to the Local Management Entity (LME) responsible for the catchment area where services were provided within 72 hours of becoming aware of the incident CROSS REFERENCE: 10A NCAC 27E .0104 Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices used for Behavioral Control (c) (V517) Based on record reviews and interviews, the facility failed to follow its policy on isolation time out and ensure restrictive interventions were not used as a means of coercion, punishment or retaliation affecting 1 of 1 former clients (Former Client #3)	responsibilities performed by the Qualified Professional (QP) occurred in the facility. All QP's will develop strategies that deescalate out of control behaviors. The QP's will also ensure that 70% of the clinical and administrative responsibilities performed by the Qualified Professional (QP) will occur in the facility when children and adolescents are awake and present in the home. QP's will ensure that PCP's are client specific to supp client behaviors. Also, QP's and AP's will demonstrate system of care to help ensure better communication amongst all agencies that's involved with the clients. QP's and AP's will also communicate with outside therapist and service providers to make sure a line of communication has been established. QP's and AP's will ensure that outside therapist and service providers are apart of the CFT meetings to make sure all professionals are involved and communicating.	Implementation Date: 7-30-18 Completion Date: Immediately and ongoing Implementation Date: 7-30-18 Completion Date: Immediately and ongoing
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CROSS REFERENCE: 10A NCAC 27E.0108
Training in Seclusion, Physical Restraint and
Isolation Time-Out (V537) Based on record
review and interview, the facility failed to ensure
staff competence in implementing restrictive
interventions with clients that were appropriate
and safe and ensure staff compliance with
facility
policy and procedures in the use of restrictive
interventions affecting 1 of 2 clients (Client #1)
1
of 2 former clients (Former Client #3).
Review on 7/13/18 of an initial Plan of
Protection

V 293 Continued From page 41 V 293

dated on 7/13/18 and signed by the Chief
Executive Officer revealed:
What will you immediately do to correct the
above
rule violations in order to protect clients from
further risk or additional harm?
"1. Review Person Centered Plan and assess
client needs by staff
" Identify any additional needs of the needs
" Review service notes and the communication
log
2. Client will be notified of the exact length of
time
of room restriction. Restriction will last no more
than 3 hours in a 24 hr. day period. Will not
exceed no more than 1 day. In service training
on
proper use of room restriction will be completed
3. Staff will complete in service training and
review IRIS Incident Reporting and categories to
determine incident level and who will need to be
contacted after incident has occurred.
CEO will conduct grid training with staff.
Coordination of care will be reviewed
4. Staff will go through in service training on
supervision in order to increase skills and three

staff will be assigned to certain shifts as needed when dealing with clients with harmful behaviors.

5. In service training on agency communication will be completed. The CEO will oversee weekly staffing with QP's, AP's, Clinical Team and House managers.

Describe your plans to make sure the above happens.

6. The CEO will oversee the implementation of this plan."

Review on 7/30/18 of an amended Plan of Protection dated on 7/30/18 by the Chief Executive Officer revealed:

"1. Review Person Centered Plan and assess client needs by staffing

V 293 Continued From page 42 V 293

- " Identify any additional needs of the clients
- " Review service notes and commutation log
- 2. Client will be notified of exact length of time of room restriction. Restriction will last no more than 3 hours in a 24 hr. day period. Will not exceed no more than 1 day. In service training on proper use of room restriction will be completed
- 3. Staff will complete in service training and review IRIS Incident Reporting and categories to determine incident level and who need to be contacted after incident has occurred. CEO will conduct grid training with staff. Coordination of care will be reviewed
- 4. Staff will go through in service training on supervision in order to increase skills and three staff will be assigned to certain shifts as needed when dealing with clients with harmful behaviors.
- 5. In service training on agencies commutation will be completed. CEO will oversee weekly

Implementation Date:
7-30-18

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Immediately and ongoing

staffing with QP's, AP's, Clinical Team and House managers. 6. In service training with therapist on proper documentation time of clients therapy and direct care staff supervision. 7. The CEO will oversee the implementation of this plan." Client #1 (age 10), Former Client #3 (age 11) and Former Client #4 (age 15) presented with diagnoses of Oppositional Defiant Disorder (ODD), Post-traumatic Stress Disorder (PTSD) and Attention-deficient Hyperactivity Disorder (ADHD). They also presented with behaviors of yelling and screaming, using profanity, imitation, throwing objects (chairs), destroying property, refusing to follow directions, verbally threatening harm and physically harming others. The responsible QPs had not updated the clients' treatment plans with strategies to address the increase in behaviors. Based on staff <u>V 293 Continued From page 43 V 293</u> documentation, staff used restrictive interventions including a hold on Client #1 for 1 hour and room restriction on Former Client #3 for up to 5 days as punishment and all with no approval or guidance from the QPs of the facility. QP #1/House Manager and QP #2/Executive Director failed to provide supervision to staff on the use of restrictive interventions as well as overall supervision in the home. The facility had no AP on staff to have direct supervision of the paraprofessional staff and the LP had not provided the required 4 hours a week of client therapy and clinical supervision in the home. In	Implementation Date: 7-30-18 Projected Completion Date: Immediately and ongoing
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the staff communication notes between 1/30/18 to 7/2/18, there were at least 25 documented occasions of client behaviors involving yelling and screaming, using profanity, imitation, throwing objects (chairs), destroying property, refusing to follow directions, verbally threatening harm and physically harming peers and staff. The systemic failures of the facility resulted in multiple incidents of unsafe, disruptive and defiant client behaviors that caused serious risks to the overall safety of individuals in the home and constitutes a Type A1 rule violation for 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 administrative penalty of \$500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day. V 294 27G .1702 Residential Tx. Child/Adol - Req. for Q P 10A NCAC 27G .1702 REQUIREMENTS OF QUALIFIED PROFESSIONALS (a) Each facility shall utilize at least one direct care staff who meets the requirements of a <u>V 294 Continued From page 44 V 294</u> qualified professional as set forth in 10A NCAC 27G .0104(18). In addition, this qualified professional shall have two years of direct client care experience. (b) For each facility of five or less beds: (1) the qualified professional specified in Paragraph (a) of this Rule shall perform clinical and administrative responsibilities a minimum of 10 hours each week; and (2) 70% of the time shall occur when children or adolescents are awake and present in the facility. (c) For each facility of six or more beds:	10A NCAC 27G.1702 Exhibit (D) Ann QP will be specified in job performance. Qualified Professional as set forth in 10A NCAC 27G .0104(18). In addition, this qualified professional shall have two years of direct client care experience. Also, QP will perform clinical and administrative responsibilities of 10 hours a week. Projected Completion Date: 7-30-18 Implementation Date: Immediately and ongoing
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(1) the qualified professional specified in Paragraph (a) of this Rule shall perform clinical and administrative responsibilities a minimum of 32 hours each week; and
(2) 70% of the time shall occur when children or adolescents are awake and present in the facility.
(d) The governing body responsible for each facility shall develop and implement written policies that specify the clinical and administrative responsibilities of its qualified professional(s).
At a minimum these policies shall include:
(1) supervision of its associate professional(s) as set forth in Rule .1703 of this Section;
(2) oversight of emergencies;
(3) provision of direct psychoeducational services to children or adolescents;
(4) participation in treatment planning meetings;
(5) coordination of each child or adolescent's treatment plan; and
(6) provision of basic case management functions.

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This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure that 70% of the clinical and administrative responsibilities performed by the Qualified Professional (QP) occurred in the facility when children and adolescents were awake and present in the home. The findings are:
Review on 7/3/18 of Qualified Professional #1/House Manager (QP #1/HM)'s personnel record revealed:
-Hire date was 7/18/14
-She met the requirements for a QP.

Review on 7/3/18 of the Qualified Professional #2/Executive Director (QP #2/ED) revealed: -She met the requirements for a QP. Review on 7/9/18 of the QP #1/House Manager's work schedule from 6/18/18-7/16/18 revealed: -Administrative hours worked was less than 10 hours a week (4:00-8:00 pm); -No administrative hours were worked for the week 6/18/18-6/24/18; -Worked 3rd shift the week on 6/23/18 (8:00 pm-8:00 am) and 7/2/18 (11:00 pm-8:00 am). Interview on 7/3/18 and 7/9/18 with QP #1/HM revealed: -She became a Qualified Professional (QP) 2 years ago; -She worked as a QP and a House Manager at separate times; -She sometimes worked 3rd shift as one of two direct care staff; <u>V 294 Continued From page 46 V 294</u> -She was the 3rd staff in the facility during her QP time; -She was the QP and House Manager for 2 other facilities under the licensee; -Her supervisor was the Qualified Professional #2/Executive Director (QP #2/ED); -She did not complete or update client treatment plans; -Her administrative time was spent as the Qualified Professional; -Her QP duties: -reviewed client treatment plans at client admission and when updated; -reviewed and signed off on daily client service notes by staff that were entered into the clients' treatment record;		Implementation Date: 7-30-18 Projected Completion Date: Immediately and ongoing
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-ensured staff worked with the clients on their treatment goals; -started attending Child and Family Team (CFT) meetings; -worked directly with clients on coping with emotions, problem-solving, and communication skills; -discussed client incidents with staff and notified the QP #2/ED of client incidents; -provided written client incident reports to the QP #2/ED. Interview on 7/2/18-7/13/18 with the QP #2/ED revealed: -QP #1/HM worked shifts in the facility; -QP #1/HM's administrative and direct care staff hours were separated; -Administrative hours were for the Qualified Professional time; -"We have to keep up with [QP #1/HM]'s hours to include working time and administrative time"; -There was no Associate Professional (AP) on staff at the facility; -QP #2/ED stated that she understood she and		Implementation Date: 7-30-18 Projected Completion Date: Immediately and ongoing
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V 294 Continued From page 47 V 294

QP #1/HM could share in the QP time at the facility;
 -7/13/18, QP #2/ED did not provide requested documentation of her QP time worked in the facility for review.
 This deficiency is cross referenced into 10A NCAC 27G .1701 SCOPE (V293) for a Type A1 rule violation and must be corrected within 23 days.
 V 295 27G .1703 Residential Tx. Child/Adol -
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10A NCAC 27G .1703 REQUIREMENTS FOR

ASSOCIATE PROFESSIONALS

- (a) In addition to the qualified professional specified in Rule .1702 of this Section, each facility shall have at least one full-time direct care staff who meets or exceeds the requirements of an associate professional as set forth in 10A NCAC 27G .0104(1).
- (b) The governing body responsible for each facility shall develop and implement written policies that specify the responsibilities of its associate professional(s). At a minimum these policies shall address the following:
- (1) management of the day to day day-to-day operations of the facility;
 - (2) supervision of paraprofessionals regarding responsibilities related to the implementation of each child or adolescent's treatment plan; and
 - (3) participation in service planning meetings.

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This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to have at least one direct care staff who met the requirements of an Associate Professional (AP) and was responsible for the supervision of the direct care staff's implementation of each child's treatment plan and participated in service planning meetings. The findings are:
Review on 7/3/18 of sampled staff personnel records revealed:
-No full-time direct care staff who met the requirements of an AP.
Interview on 7/2/18 with Staff #1 revealed:
-She was a direct care staff and had worked at the facility since 2016;
-Her education beyond high school was in

V295 27G .1703 See Attachment (E)

Peace in the City will employ ASSOCIATE PROFESSIONALS
(a) In addition to the qualified professional specified in Rule .1702 of this Section, each facility shall have at least one full-time direct care staff who meets or exceeds the requirements of an associate professional as set forth in 10A NCAC 27G .0104(1).

cosmetology. Interview on 7/13/18 with Staff #4 revealed: -He was a lead direct care staff and Medication Supervisor; -He had community college education beyond his high school diploma. Interview on 7/9/18 with Qualified Professional #1/House Manager (QP #1/HM) revealed: -She did some supervision of the direct care staff; -The Qualified Professional #2/Executive Director (QP #2/ED) and Chief Executive Officer (CEO) helped in the supervision of direct care staff; -A Lead Direct Care Staff (Staff #1) helped her oversee the other direct care staff when Staff #1 was on duty and to answer staff questions; -She made suggestions about changes to clients' care and treatment plans to QP #2/HM and the CEO; <u>V 295 Continued From page 49 V 295</u>	(b) The governing body responsible for each facility shall develop and implement written policies that specify the responsibilities of its associate professional(s). At a minimum these policies shall address the following: (1) management of the day to day day-to-day operations of the facility; (2) supervision of paraprofessionals regarding responsibilities related to the implementation of each child or adolescent's treatment plan; and (3) participation in service planning meetings.	Implementation Date: 7-30-18 Projected Completion Date: Immediately and ongoing
-She started attending the Child and Family Team meetings; -When she worked 3rd shift as direct care staff, she took inventory of the food and cleaning supplies to make sure the facility had enough supplies for daily use. Interview on 7/2/18 with the Qualified Professional #2/Executive Director (QP #2/HM) revealed: -There was not an Associate Professional (AP) on staff at the facility; -Qualified Professional #1/House Manager (QP #1/HM) was responsible for management of the daily operations of the facility; -She (QP #2/HM), the CEO and QP #1/HM filled the duties of an AP;		Implementation Date: 7-30-18 Projected Completion Date:

- 2 Lead Direct Care Staff (Staff #1 and Staff #4) assisted QP #1/HM with facility operations (ensuring clients had their medications, serving as the second direct care staff member; -She assisted QP #1/HM when needed in supervision of the direct care staff to ensure staff were working with the clients on their treatment goals and activities. This deficiency is cross referenced into 10A NCAC 27G .1701 SCOPE (V293) for a Type A1 rule violation and must be corrected within 23 days. V 297 27G .1705 Residential Tx. Child/Adol - P Req. for L 10A NCAC 27G .1705 REQUIREMENTS OF LICENSED PROFESSIONALS (a) Face to face clinical consultation shall be provided in each facility at least four hours a week by a licensed professional. For purposes of	V 297 Continued From page 50 V 297 this Rule, licensed professional means an individual who holds a license or provisional license issued by the governing board regulating a human service profession in the State of North Carolina. For substance-related disorders this shall include a licensed Clinical Addiction Specialist or a certified Clinical Supervisor. (b) The consultation specified in Paragraph (a) of this Rule shall include: (1) clinical supervision of the qualified professional specified in Rule .1702 of this Section; (2) individual, group or family therapy services; or (3) involvement in child or adolescent specific treatment plans or overall program issues. This Rule is not met as evidenced by: Based on record review and interview, the facility	Peace in the City along with Licensed Professional has revamped the log book to show weekly hours and to ensure the clinical consultation of the Qualified Professionals (QPs) and provision of individual and group therapy services by the Licensed Professional (LP) at least four hours per week. V297 27G .1705 10A NCAC
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Immediately and ongoing

failed to ensure the clinical consultation of the Qualified Professionals (QPs) and provision of individual and group therapy services by the Licensed Professional (LP) at least four hours per week. The findings are:
 Review on 7/3/18 of the Licensed Professional (LP)'s personnel record revealed:
 -Hire date: 9/11/17;
 -Credentialed as a Licensed Professional Counselor and Licensed Clinical Addiction Specialist.
 Review on 7/3/18 of the LP's therapy time at the facility revealed:
 5/6/18 -5/12/18: 1.5 hours on 5/12/18;
 5/13/18-5/19/18: 1.5 hours on 5/18/18;

V 297 Continued From page 51 V 297

5/20/18-5/26/18: 1.5 hours on 5/22/18;
 5/27/18-6/2/18: 1.5 hours on 6/1/18;
 6/3/18-6/9/18: 2 hours on 6/6/18;
 6/10/18-6/16/18: 1.25 hours on 6/16/18;
 6/17/18-6/23/18: 2 hours on 6/20/18;
 6/24/18-6/30/18: 2 hours on 6/27/18.
 Interview on 7/9/18 with the LP revealed:
 -He provided individual and group therapy to the clients;
 -The therapy to clients varied each visit from 1.5 to 2 hours;
 -He provided staff with clinical supervision and training at the facility;
 -The Qualified Professional #2/Executive Director (QP #2/ED) had a record of his clinical supervision hours with staff;
 -He did not know the amount of hours spent in staff clinical supervision and training
 -He worked at the facility after his regular work hours.
 Interview on 7/2/18 and 7/13/18 with the QP #2/ED revealed:

-7/13/18, no documentation provided of the LP's time in clinical supervision and training time of staff provided for review. This deficiency is cross referenced into 10A NCAC 27G .1701 SCOPE (V293) for a Type A1 rule violation and must be corrected within 23 days. V 366 27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and	V 366 Continued From page 52 V 366 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 V366 27G .0603 Peace in the City will call proper personnel in the event of an incident taking place. Peace in the City shall determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;
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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:

(1) immediately securing the client record by;

(A) obtaining the client record;

(B) making a photocopy;

(C) certifying the copy's completeness; and

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(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 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

V 366 Continued From page 54 V 366

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**

regarding

their response to incidents and failed to track client behaviors. The findings are:

Review on 7/6/18 of the facility's undated written

Incident Response/Reporting Policy revealed:

-Staff was to complete an incident report on client

incidents that were not part of routine client care and could have resulted in adverse effects on a client;

Refer to V367 for incident reports from 3/2018 through 6/2018.

Review on 7/3/18 of Client #1's record revealed:
Date of admission: 5/23/18

Diagnoses: Oppositional Defiant Disorder,
Attention-deficient Hyperactivity Disorder
Combined Presentation

Age: 10

V 366 Continued From page 55 V 366

Review on 7/3/18-7/12/18 of staff communication

notes 6/3/18-7/2/18 that pertained to Client #1 revealed:

-6/6/18, 6/8/18 and 6/29/18, was physically restrained by staff;

-6/5/18, 6/6/18, 6/10/18, 6/13/18 and 6/14/18, was

placed on room restriction;

-Refer to V 112 for detailed information on the incidents.

Review on 7/3/18 of Former Client #3 (FC #3)'s record revealed:

Date of admission: 5/25/17

Date of discharge: 6/15/18

Diagnoses: Oppositional Defiant Disorder,
Attention-deficient Hyperactivity Disorder,
Post-traumatic Stress Disorder, Eczema

Age: 11

Review on 7/3/18-7/12/18 of staff communication

notes on FC #3 from 1/29/18 to 6/15/18 revealed:

- 4/13/18, 5/3/18, 5/6/18, and 5/22/18, was physically restrained by staff;
- 1/30/18-2/5/18 (5 days), 4/7/18-4/11/18 (4 days), 4/13/18-4/18/18 (5 days), and 6/14/18, was placed on room restriction by staff;
- No staff notes that staff activated FC #3's crisis plan to call 911 if FC #3 harmed self and medical or police assistance was required.
- Refer to V 112 for detailed information on the incidents.

Interview on 7/3/18 with FC #3 revealed:

- He denied he ran or laid down in the road at any time;
- One time staff thought he was running away, staff chased him and held him so he could not move;
- He was restrained by staff for punching holes in the walls and trying to harm himself but did not

V 366 Continued From page 56 V 366

know how many times he was physically restrained by staff;

- He described he was restrained by staff different ways:
- Staff stood behind him with their arms "hugged" around his arms which were crossed in front of him;
- 1 staff kneeled over top of him lying on the floor and held his hands behind him;
- 2 staff with 1 staff having held his hands and 1 staff held his legs and he was lying down;
- He stated staff never used anything but their hands when he was restrained;
- He was sent to his room multiple times to stay by staff because of his behaviors.

-FC #3 was unable to give specific dates but was able to describe staff responses when he and his peers fought, when he was angry at his peers and staff, and punched holes in his bedroom walls. Interview on 7/3/18 and 7/9/18 with the Qualified Professional #1/House Manager (QP #1/HM) revealed:

- She was aware FC #3 was restrained by staff because he tried multiple times to harm his peers and staff and safety was of concern;
- She recalled FC #1 ran outside and into the road 1 week before his discharge because he was upset;
- She was uncertain whether or not staff completed an incident report on the aforementioned incident;
- Staff was to notify her any time a client had been injured or had to be restrained;
- She came to the facility to talk with clients when staff was unsuccessful in re-directing clients in calming down their emotions and notified her;
- Staff was expected to attend to the client first and then notify her about a client injury or restraint;

V 366 Continued From page 57 V 366

- Staff involved directly with a client who had been injured or restrained was responsible for completing and submitting to her a written incident report;
- She was unaware of many of the client incidents reported in the staff communication notes from 1/29/18-7/2/18
- She notified the Qualified Professional #2/Executive Director (QP #2/ED) of client incidents related to a client injury or restraint by staff;

Implementation Date: 7-30-18
Projected Completion Date:
Immediately and ongoing

-She was responsible for ensuring the written incident reports were provided to the QP #2/ED. Interview on 7/2/18 with the QP #2/ED revealed: -There were no physical fights between the clients; -Client conflict (arguing) was usually deescalated by use of room restriction for the client(s) to have time to calm down; -Staff were trained to use restraints on clients but restraints were used as a last resort; -1 staff usually was involved in restraining a client while the 2nd staff member supervised the other clients; -There should be an incident report any time a client is restrained; -Staff were expected to call her and inform her if a client was restrained so she could find out the reason for the restraint. This deficiency is cross referenced into 10A NCAC 27G .1701 SCOPE (V293) for a Type A1 rule violation and must be corrected within 23 days. V 367 27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT <u>V 367 Continued From page 58 V 367</u> 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	Peace in the City will report all level 2 and 3 incidents to LME, Executive Director and other proper policy and procedure guideline. (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
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responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information	rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains	Implementation Date: 7-30-18
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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). (c) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. <u>V 367 Continued From page 60 V 367</u> This Rule is not met as evidenced by: Based on interview and record review, the facility failed to report Level II incidents to the Local Management Entity (LME) responsible for the catchment area where services were provided	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	Projected Completion Date: Immediately and ongoing
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within 72 hours of becoming aware of the incident. The findings are: Review on 7/6/18 of the facility's undated written Incident Response/Reporting Policy revealed: -A Level I incident was to be documented on an internal incident form; -Level II and III incidents would be completed and reported into the North Carolina Incident Response Improvement System (IRIS); -A statement that all incidents would be documented and analyzed as part of quality assurance and improvement processes; -Reportable incidents included: -Any restrictive intervention used in an unplanned, emergency situation; -Planned restrictive interventions, but administered improperly or without proper authorization, by staff without proper training, or for longer than the authorized period; -Any sexual, aggressive, or destructive behavior ... or a potentially serious threat to the health or safety of self or others; -The person who initiated the restraint on a client would complete an incident report within 24 hours of use. Review on 7/2/18 of Incident Reports from 3/2018 through 6/2018 revealed: -A 5/3/18 incident report that pertained to Former Client #3 (FC #3) revealed: <u>V 367 Continued From page 61 V 367</u> -FC #3 took off his seatbelt during transportation on the van, grabbed a gallon of milk from the house groceries, and threw a milk jug hitting Staff #3 in the back of the head; -The milk jug bounced off Staff #3, hit a peer seated in front passenger seat, and the incident			Implementation Date: 7-30-18 Projected Completion Date: Immediately and ongoing
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"nearly causing a vehicle accident";
 -FC #3 was escorted off the van upon return to the facility, placed in a therapeutic hold by Staff
 #3 because FC #3 attempted to assault him and was held "until [FC #3] calmed down;
 -6/3/18, FC #3 banged his head on a wall until nose bled and staff applied first aid to FC #3 and monitored him during the night;
 -6/8/18 and 6/11/18 FC #3 kicked holes in his bedroom wall;
 -6/28/18, Client #2 had a red area on his arm after taking a shower, told staff he had rubbed his arm too hard, and staff provided ice to Client #2 to apply to his arm;
 -No incident reports:
 -for period 1/1/18 to 5/2/18 on current Clients #1 and #2 and Former Clients #3 and #4;
 -Client #1 was restrained by staff on 6/6/18, 6/8/18 and 6/29/18;
 -FC #3 was restrained by staff on 4/13/18, 5/6/18, and 5/22/18;
 -no facility-identified Level II and/or III incidents;
 -no completed and submitted incident reports in IRIS for review on current Clients #1 and #2 and Former Clients #3 and #4;
 Review on 7/3/18 of Client #1's record revealed:
 Date of admission: 5/23/18
 Diagnoses: Oppositional Defiant Disorder, Attention-deficient Hyperactivity Disorder Combined Presentation
 Age: 10
 A review on 7/3/18-7/12/18 of staff

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communication notes between 6/3/18-7/2/18 that pertained to Client #1 revealed:
 -6/6/18, 6/8/18 and 6/29/18, was physically restrained by staff;
 -6/5/18, 6/6/18, 6/10/18, 6/13/18 and 6/14/18,

was placed on room restriction; -Refer to V 112 for details of client incidents on the aforementioned dates. Review on 7/3/18 of FC #3's record revealed: Date of admission: 5/25/17 Date of discharge: 6/15/18 Diagnoses: Oppositional Defiant Disorder, Attention-deficient Hyperactivity Disorder, Post-traumatic Stress Disorder, Eczema Age: 11 Review on 7/3/18-7/12/18 of staff communication notes on FC #3 between 1/29/18 -6/15/18 revealed: -4/13/18, 5/3/18, 5/6/18, and 5/22/18, was physically restrained by staff; -1/30/18-2/5/18 (5 days), 4/7/18-4/11/18 (4 days), 4/13/18-4/18/18 (5 days), and 6/14/18, was placed on room restriction by staff; -No staff notes that staff activated FC #3's crisis plan to call 911 if FC # harmed self and medical or police assistance was required. -Refer to V 112 for details of client incidents on the aforementioned dates. Interview on 7/2/18 with Client #1 revealed: -Stated that one time while on the van, FC #3 "started his stuff" and he (Client #1) took off his seatbelt and tried to choke FC #3; -The staff who drove the van pulled over and FC #3 accused him (Client #1) of hitting him; -Another staff who was on the van told FC #3 to stop it. <u>V 367 Continued From page 63 V 367</u> Interview on 7/3/18 with FC #3 revealed: -He was restrained by staff for punching holes in the walls and trying to harm himself but did not know how many times; -He stated staff never used anything but their hands when he was restrained;		Implementation Date: 7-30-18 Projected Completion Date: Immediately and ongoing
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-Former Client #4 (FC #4) had hit him on his back with a clothes hanger while he (FC #3) was restrained by staff on his bedroom floor for punching holes in the wall.
Interview on 7/5/18 with FC #4 revealed:
-He had physical fights with his peers that included FC #3;
-He denied he hit FC #3 with a clothes hanger while FC #3 was restrained by staff;
Interview on 7/2/18 with Staff #1 revealed:
-No incident report was completed on FC #3 after he hit her in the stomach and tied to stab her with a toy because FC #1 had calmed down.
Interview on 7/2/18 with Staff #3 revealed:
-He had completed an incident report on the 5/3/18 incident where FC #3 hit him with the milk jug during transport and FC #3 was restrained for kicking him.
Interview on 7/3/18 and 7/9/18 with the Qualified Professional #1/House Manager (QP #1/HM) revealed:
-Staff involved directly with a client who had been injured or restrained was responsible for completing a written incident report;
-She was responsible for ensuring the written incident reports were provided to the Qualified Professional #2/Executive Director (QP #2/ED);
-She did not determine the levels of the client incident reports;
-If a client was causing harm to self or others or

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there was property destruction, the incident

would be a Level II or III. Interview on 7/2/18 with the QP #2/ED revealed: -There were no Level II or Level III client incident reports from 1/2018 through 6/2018 because there was no client injuries beyond first aid and no police or medical emergency involvement; -She had received IRIS training in 12/2017 and was familiar with the criteria for determining Level I, II, and III incidents; -A clinical team met monthly, reviewed client incident reports, and made decisions as to what level would be assigned to each incident report; -The clinical team was made up of the Chief Executive Officer (CEO), QP #2/ED, QP #1/House Manager, the Licensed Professional (LP), and a Direct Care Staff member; -Administrative staff entered and submitted the Level II and III incident reports into IRIS. This deficiency is cross referenced into 10A NCAC 27G .1701 SCOPE (V293) for a Type A1 rule violation and must be corrected within 23 days. V 517 27E .0104(c-d) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (c) Restrictive interventions shall not be employed as a means of coercion, punishment or retaliation by staff or for the convenience of staff or due to inadequacy of staffing. Restrictive interventions shall not be used in a manner that causes harm or abuse. (d) In accordance with Rule .0101 of Subchapter		V517 27E .0104 10A NCAC
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27D, the governing body shall have policy that delineates the permissible use of restrictive interventions within a facility. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure restrictive interventions were not used as a means of coercion, punishment or retaliation by staff or for the convenience of staff affecting 1 of 1 former clients (Former Client #3). They findings are: Review on 7/3/18 of Former Client #3 (FC #3)'s record revealed: Date of admission: 5/25/17 Date of discharge: 6/15/18 Diagnoses: Oppositional Defiant Disorder (ODD), Attention-deficient Hyperactivity Disorder (ADHD), and Post-traumatic Stress Disorder (PTSD) Age: 11 -FC #3's treatment plan did not identify room restriction as a treatment strategy. Review on 7/3/18-7/12/18 of staff communication notes between 1/29/18 to 6/15/18 revealed: -A 3rd shift staff-signed note that pertained to FC #3: -1/30/18, attempted physical assault on a peer with a fork; -Contained the following statements: -"Don't know if you put young boys on room restriction but definitely needs punished! for his consequences and behavior"; -"I did tell [FC #3] he was on room restriction when home from school and no toys!" -1/31/18, a note by the same staff who placed FC #3 on room restriction on 1/30/18 contained the following statements:	Peace in the City along with treatment team will incorporate into PCP Plan the use of physical restraint and time out. Also, Peace in the City will provide refresher training must be completed by each staff.
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-"[FC #3] continues on room restriction"; -Clients well-behaved during morning routine"; -"[FC #3] better this am!" -2/1/18, a note by another staff person that FC #3 verbally threatened to harm a staff with pencils, chairs and toys after staff removed him from the shower; -Contained the following statement: "[Qualified Professional #2/Executive Director] said 3 more days of room restriction"; -2/3/18, a note by another staff person with statement "[FC #3] is still on room restriction until Monday"; -FC #3 was placed on room restriction on 1/30/18-2/5/18 (5 days), 4/7/18-4/11/18 (4 days), 4/13/18-4/18/18 (5 days), and 6/14/18. Interview on 7/3/18 with FC #3 revealed: -He was sent to his room multiple times when he was angry but could not indicate any dates; -"If I was mad at something, staff would tell me 'go to your room'"; -He was not allowed to come out of his room until staff told him he could; -He could come out of his room to eat his meals at the dining table and to use the bathroom; -Stated the amount of time he stayed in his room was different each time and he did not know why; -He stated that sometimes he had to stay in his room every day after school. Interview on 7/9/18 with the Qualified Professional #1/House Manager (QP #1/HM) revealed: -Room restriction was used by staff for a client to have time to themselves in their room to calm down when angry or agitated; -Clients on room restriction were allowed to participate with other clients in meals at the dining table, attend school and use the bathroom;			
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-Clients had access to use their televisions and radios in their own rooms;
-Clients who fought and did not want to listen to staff were placed on room restriction for 24 hours but they usually came out of room restriction earlier than 24 hours;
-Clients who continued to be non-compliant with staff, remained agitated or needed extra time to themselves could have their room restriction extended by staff up to 48 hours;
-Direct care staff were allowed to decide on use and duration of room restriction for a client;
-Room restriction was not to be used by staff to punish clients but used to help clients calm their emotions and behavior;
-The QP #1/HM stated that she was not aware of any staff who used room restriction to punish a client;
-No response by the QP #1/HM to the 1/30/18 staff communication note that contained the statement: "Don't know if you put young boys on room restriction but definitely needs punished! for his consequences and behavior."
Interview on 7/9/18 with the Qualified Professional #2/Executive Director (QP #2/ED) revealed:
-Room restriction occurred when the clients were told to go to their rooms because they were not doing what they were supposed to;
-Clients on room restriction had their televisions in their room to use and clients were allowed to come out of their rooms for bathroom use, attend school/day program and for meals;
-Clients on room restriction were not allowed into the common areas and participate in group

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recreational activities; -The use of room restriction for a client was decided by the direct care staff but were expected to call her and let her know the client's situation; <u>V 517 Continued From page 68 V 517</u> -Room restriction for clients was used for a few hours to half a day and not used to punish a client; -There were no clients placed on room restrictions longer than a few hours. This deficiency is cross referenced into 10A NCAC 27G .1701 SCOPE (V293) for a Type A1 rule violation and must be corrected within 23 days. 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		Projected Completion Date: 7-30-18 Implementation Date: Immediately and ongoing
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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, <u>V 537 Continued From page 69 V 537</u> include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the		V537 27E .0108 Peace in the City staff will do in-service training and recertification on seclusions physical restraints and isolation. In service training will include de-escalation, proper use of time out and restrain, recertification and physical restraints.	Projected Completion Date: 7-30-18 Implementation Date: Immediately and ongoing
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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: <u>V 537 Continued From page 70 V 537</u> (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule.	Implementation Date: 7-30-18 Projected Completion Date: Immediately and ongoing
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(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 <u>V 537 Continued From page 71 V 537</u> of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached.	Implementation Date: 7-30-18 Projected Completion Date: Immediately and ongoing
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(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 review and interview, the facility

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failed to ensure staff competence in implementing restrictive interventions with clients that were appropriate and safe and ensured staff compliance with facility policies and procedures in the use of restrictive interventions affecting 1 of 2 clients (Client #1) 1 of 2 former clients (Former Client #3). The findings are:
Review on 7/6/18-7/12/18 of the facility's undated policy on Client Rights/Restrictive Interventions revealed:

- Page 173:
- Contained the following statements "[Facility] does not utilize seclusion or isolation time out. However, when situations warrant it client would be asked to go to room";
- Defined physical restraint as:
- "any manual method that restricts freedom of movement";
- "Holding a client in a therapeutic hold or any other means that restricts his or her movement constitutes manual restraint for that client";
- Page 179 had statements that pertained to staff competency in the use of restraints:
- "If, at any point, a question arises regarding the employee's competence to carry out restrictive intervention appropriately and safely, then [Facility] has the right to require the employee

be retrained"; "In this event, privileging in restrictive intervention will be pulled until the retraining and competence is completed and verified"; -"In this event, privileging in restrictive intervention will be pulled until the retraining and competence is completed and verified" -Whenever a restraint was utilized on a client, the Qualified Professionals duties included: -a review of each use of a restraint; -immediate feedback to the employee who used the restraint; <u>V 537 Continued From page 73 V 537</u> -notification of others (treatment team member, designee of the governing body, and the parent or legally responsible person of a minor child) when restrictive intervention was used. Review on 7/3/18 of staff personnel records for the Chief Executive Officer (CEO), Qualified Professional #2/Executive Director (QP #2/ED), Qualified Professional #1/House Manager (QP #1/HM), and Direct Care Staff #1-#3 revealed: -All staff had current certification through 9/2018 on a state-approved training on the use of de-escalation strategies and restrictive interventions; -Staff were trained in restraint blocks, therapeutic holds, releases, transports, and carries as indicated by the certified instructor's initials and signature on the back of staff training certificates. Review on 7/13/18 of a participant workbook that		
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included visual and descriptive restraints of a state-approved training on restrictive interventions that was used by the facility revealed: -No identified restraint was revealed of a person: -in a seated position such as on a couch or in a chair; -lying with stomach and facing the floor; -kneeling over the person restrained with hands held behind; -lying down with 1 person holding the restrained person's hands and one person holding the restrained person's legs. Review on 7/3/18-7/12/18 of staff communication notes between 6/3/18-7/2/18 that pertained to Client #1 revealed: -6/8/18, yelled, screamed, attempted to hit Former Client #4, and "had to restrain [Client #1] and hold him on couch 1 hr until he calmed down"; <u>V 537 Continued From page 74 V 537</u> -There were no staff statements that included: -de-escalation strategies used by staff with Client #1 before staff applied a therapeutic hold (manual); -whether staff reviewed or considered Client #1's health status before, during and after a restraint was applied; -a description of how Client #1 was held on the couch; -authorization for the continued use of the restraint; -reference to completed incident reports regarding restraints placed on Client #1 on 6/6/18, 6/8/18, and 6/29/18. Review on 7/3/18-7/12/18 of staff communication notes on FC #3 from 1/30/18 to 6/15/18		Implementation Date: 7-30-18 Projected Completion Date: Immediately and ongoing
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revealed: -4/13/18, 5/3/18, 5/6/18, and 5/22/18, was placed in a therapeutic hold or restraint by staff; -There were no staff statements that included: de-escalation strategies used by staff with FC #3 before staff applied a therapeutic hold (manual); -the type(s) or a other description of the therapeutic holds used by staff; -whether staff considered FC #3's health status before, during and after a restraint was applied; -a specific duration of time each incident of restraint was used by staff; -reference to completed incident reports regarding restraints placed on FC# 3 on 4/13/18, 5/6/18 and 5/22/18. Interview on 7/3/18 with FC #3 revealed: -He was restrained by staff for punching holes in the walls and trying to harm himself but did not know how many times; -He was hit by Former Client #4 (FC #4) with a clothes hanger while restrained by staff on his		
<u>V 537 Continued From page 75 V 537</u>		
bedroom floor; -He described he was restrained by staff different ways; -Staff stood behind him with their arms "hugged" around his arms which were crossed in front of him; -1 staff kneeled over top of him lying on the floor and held his hands behind him; -2 staff with 1 staff having held his hands and 1 staff held his legs and he was lying down; -He stated staff never used anything but their hands when he was restrained. Interview on 7/5/18 with FC #4 revealed: -He removed a book from under FC #3's stomach while FC #3 was restrained by staff on the		

bedroom floor; -FC #3 was faced toward the floor for a book to be removed from his stomach. Interview on 7/30/18 with a certified trainer from a state-approved training on restrictive interventions that was used by the facility revealed: -A therapeutic restraint of a client on the floor was an improper use of a restraint; -Additional information was needed about a hold placed on a client on a couch to determine if was improper. This deficiency is cross referenced into 10A NCAC 27G .1701 SCOPE (V293) for a Type A1 rule violation and must be corrected within 23 days. V 736 27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS	V 736 Peace in the City will continue to make repairs and each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.
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-Client #1's bathroom sink vanity was missing left side door;

-No clothes bar in Client #1's closet for Client #1 to hang his clothes;

-3 broken floor tiles in hallway near the kitchen and office;

-2 large holes in the wall and 1 large plastered and unpainted area on wall in bedroom that was Former Client #3's (FC #3) bedroom;

-2 holes in the closet of FC #3's bedroom with a large piece of plywood attached to the back of FC #3's closet and no bar inside the closet to hang clothes;

-2 broken drawers on dresser in Client #2's bedroom.

Interview on 7/9/18 with the House Manager/Qualified Professional #1 (HM/QP #1) revealed:

-The living room sofa and chair hit against the

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blinds the reason they were broken;

-The plastered and unpainted areas in Client #1's bedroom came from holes where Client #2 had kicked a hole in the wall when Client #2 occupied the room and the other 2 areas were holes made by former clients prior to Former Clients #3 and #4 and repaired with mesh and plaster;

-There were no closet bars in Client #1's and FC #3's bedroom because the clients preferred to fold their clothes and put into their dresser drawers instead of hanging their clothes in the closets;

-Former Client #4 had broken the dresser drawers in the bedroom occupied by Client #2.

Interview on 7/13/18 with the Executive Director/Qualified Professional #2 and the Chief Executive Officer revealed:

-They were aware that the client bedrooms needed further repair.

This deficiency constitutes a recited deficiency and must be corrected within 30 days.

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blinds the reason they were broken;
-The plastered and unpainted areas in Client #1's bedroom came from holes where Client #2 had kicked a hole in the wall when Client #2 occupied the room and the other 2 areas were holes made by former clients prior to Former Clients #3 and #4 and repaired with mesh and plaster;
-There were no closet bars in Client #1's and FC #3's bedroom because the clients preferred to fold their clothes and put into their dresser drawers instead of hanging their clothes in the closets;
-Former Client #4 had broken the dresser drawers in the bedroom occupied by Client #2. Interview on 7/13/18 with the Executive Director/Qualified Professional #2 and the Chief Executive Officer revealed:
-They were aware that the client bedrooms needed further repair.
This deficiency constitutes a recited deficiency and must be corrected within 30 days.

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Corrective Plan

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M. Miller, Sall, B.D. O.P.