STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-648	A. BUILDING: ________ B. WING ________	**09/27/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TURN AROUND	**9709 BATTEN COURT MINT HILL, NC 28227**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint survey was completed on September 27, 2018. The complaint was substantiated (Intake #NC00142685). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.	V 000		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort	V 132		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-648	A. BUILDING: ________ B. WING ________	09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TURN AROUND	**9709 BATTEN COURT MINT HILL, NC 28227**

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V 132	Continued From page 1 to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to protect clients from alleged perpetrators during an internal investigation affecting 1 of 3 audited staff (Staff #4). The findings are: Review on 9/11/18 of Staff #4's record revealed: -Date of Hire 6/10/18; -Employed as Residential Counselor. Review on 9/10/18 of an Incident Report completed through the North Carolina Incident Response Improvement System (IRIS) for an incident which occurred on 9/4/18 involving and allegation of abuse made by Client #1 against Staff #4 revealed: -" ...DSS (Department of Social Services) Social Worker arrived at the facility to investigate allegations that a staff member (Staff #4) inappropriately disciplined the consumer (Client #1) on 09/04/2018 ...;" -The report included notification of Health Care Personnel Registry (HCPR) that Staff #4 was the accused staff and Staff #5 was the witness.	V 132		

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	MHL060-648	A. BUILDING: ____ B. WING ____	09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TURN AROUND	**9709 BATTEN COURT MINT HILL, NC 28227**

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V 132	Continued From page 2 Interview on 9/10/18 with Staff #4 revealed: -An internal investigation was completed regarding the allegation of Client #3 being hit in the face by Staff #4; -Staff #4 was allowed to continue to work with Client #1 during the completion of the internal investigation. Interview on 9/26/18 with the Licensee revealed: -Completed an incident report and notification to HCPR regarding the incident on 9/4/18 involving Client #1 and Staff #4; -Spoke with Client #1 and was never told by Client #1 that she was hit by Staff #4; -An internal investigation was completed regarding the incident but Staff #4 was not removed from the facility during the investigation; -After investigations completed by DSS and DHSR (Division of Health Service Regulations), Staff #4 no longer works with Client #1.	V 132		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-648	A. BUILDING: ______ B. WING ______	09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TURN AROUND	9709 BATTEN COURT MINT HILL, NC 28227

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V 512	Continued From page 3	V 512		

is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter.
(e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.

This Rule is not met as evidenced by:
Based on interview, record review, and observation, 1 of 3 audited staff (Staff #4) subjected 1 of 3 audited clients (Client #1) to abuse. The findings are:

Review on 9/10/18 of Client #1's record revealed:
-Admission date of 12/1/17;
-Diagnoses of Attention Deficit Hyperactivity Disorder, Disruptive Mood Dysregulation Disorder, Post-Traumatic Stress Disorder, and Reactive Attachment Disorder;
-12 years old;
-Most recent treatment plan dated 8/23/18 with no documentation of difficulties encountered during transportation to and from school or community events.

Review on 9/11/18 of Staff #4's record revealed:
-Date of Hire 6/10/18;
-Employed as Residential Counselor.

Review on 9/11/18 of Staff #5's record revealed:
-Date of Hire 6/13/17;
-Employed as Residential Counselor.

Review on 9/10/18 of an Incident Report completed through the North Carolina Incident Response Improvement System (NC IRIS)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-648	A. BUILDING: ______ B. WING ______	09/27/2018

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TURN AROUND	9709 BATTEN COURT MINT HILL, NC 28227

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V 512	Continued From page 4	V 512		

completed by Licensee #7 for an incident which occurred on 9/4/18 involving an allegation of abuse made by Client #1 against Staff #4 revealed:
-" ...As the consumer (Client #1) was being transported home from school by Residential Counselor [Staff #4] she (Client #1) jumped out of the car while at a stop sign. As RC (Residential Counselor) [Staff #4] attempted to secure the consumer a member of the community apparently called the police as they arrived and stated that someone had called and reported that someone was trying to get a kid into the car. The police officers were familiar with the consumer and after she made statements that she wanted to die they transported her to [local behavioral health center] where she was evaluated and released ...allegations that a staff member (Staff #4) inappropriately disciplined the consumer (Client #1) on 09/04/2018 ...;"
-The report included notification of Health Care Personnel Registry (HCPR) that Staff #4 was the accused staff and Staff #5 was the witness.

Review on 9/24/18 of Officer/Internal Incident Report - Confidential Law Enforcement Data dated 9/4/18 regarding an incident involving Client #1 revealed:
-" ...The victim (Client #1) advised that the suspect (Staff #4) struck her with a closed fist ...;"
-" ...On September 4, 2018 I (Police Officer) responded to the 7800 block of Monroe Rd in reference to a possible assault of a minor. Upon arrival I spoke with the listed suspect [Staff #4]. The suspect advised that the victim [Client #1] is a resident of the group home [group home address] she stated that she (suspect) is an employee of the group home. She stated that she and a co-worker (Staff #5) picked the victim up from school on Monroe Road she stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-648	A. BUILDING: ______ B. WING ______	09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TURN AROUND	9709 BATTEN COURT MINT HILL, NC 28227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	Continued From page 5	V 512		

the victim jumped out of the car as it was stopped in traffic and began running away. The suspect advised that she chased after the victim and the victim was running through traffic. She advised that the victim fell on the sidewalk and that she (suspect) held her down to keep from running away again. The witness [Citizen #9] stated that she was driving down the road when she observed the suspect sitting on top of the victim and advised that the suspect was striking the victim in the face. R/O (Responding Officer) spoke with [Department of Social Services (DSS) Case Manager from client's county of origin]. He advised that the victim has been in DSS custody since she was 6yoa (years old). He stated that the victim is a high flight risk and has ran away multiple times. He stated that the victim has a history of telling strangers that she does not know the group home staff and that they are trying to kidnap her. The victim also has a history of lying to police about her identify as verified by previous KBCOPS (electronic system) reports. The victim was transported to [local hospital] by [local emergency service ambulance] for evaluation. The victim was seen by a pediatric ER (emergency room) Dr. (doctor) who advised that she is familiar with the victim from a previous case. She advised that the victim has no signs of injury. X-rays were taken which revealed no injuries. The victim was discharged from the hospital and transported back to the group home by R/O where she was released to the custody of the group home per DSS. This report is being completed for DSS purposes only ..."

Review on 9/11/18 of Hospital Discharge Documentation dated 9/4/18 at 6:58pm for Client #1 provided by Licensee #7 revealed:
-Reason for visit was a possible assault;
-No documentation of any marks or scratches or

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	MHL060-648	A. BUILDING: ______ B. WING ______	09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TURN AROUND	9709 BATTEN COURT MINT HILL, NC 28227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	Continued From page 6	V 512		

treatment;
-Discharge diagnosis was fall and neck pain;
-Patient education on "back care tips."

Interview on 9/10/18 with Client #1 revealed:
-One day last week (could not identify the specific date), Staff #4 and Staff #5 picked her up from school. "Nothing much happened." Staff #5 was driving and Staff #4 was sitting in the front passenger seat. Client #1 was in the rear seat. Staff #4 was bothering Client #1, but Client #1 refused to identify what Staff #4 was doing to bother her revealing "don't feel like it." When the car stopped at a stop sign, Client #1 got out of the car but does not know the name of the street where she got out. Staff #4 followed Client #1 while Staff #5 went up the street to make a u-turn. Staff #4 "stop me by grabbing my shirt." Staff #4 slapped Client #1 in the face. There were witnesses to the incident who stopped and helped. Staff #4 has continued to work with Client #1. Client #1 told the police who responded as well as the Licensee #8/Director of Operations that Staff #4 hit her in the face. Client #1 could not identify which police department responded. Client #1 went to the hospital in an ambulance. "The only way you are going to keep me safe is moving me out of this group home."

Interview on 9/10/18 with Staff #4 revealed:
-on 9/4/18, Staff #4 picked up Client #1 from school with Staff #5. Client #1 got into the car and revealed she wanted to go to behavioral health and not the group home. She said she wanted to jump out of the car. Staff verbally calmed her down. While at a traffic light, Client #1 got out of the car and started running. Staff #4 was not supposed to run because she was 5 months pregnant. Staff #4 caught up to Client #1 and Client #1 fell to the ground. A community

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-648	A. BUILDING: ____ B. WING ____	09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TURN AROUND	9709 BATTEN COURT MINT HILL, NC 28227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	Continued From page 7 member witnessed the incident and called the police. Staff #4 could not breathe from running. The community witness said Staff #4 "beat her (Client #1)."Client #1 was taken to the hospital by ambulance. Staff #4 reports pain in her abdomen since the incident but has not sought medical advice. Staff #4 believes she was put in jeopardy of having problems with her pregnancy. The House Manager #6 and Licensee #8/Director of Operations was aware of the incident. Interview on 9/13/18 with Staff #5 revealed: -Picked up Client #1 from school to take her to the group home. Client #1 sits in the rear seat and staff usually have the child locking system engaged. At a light in traffic, Client #1 opened the car door and began running. Staff #4 got out of the car and followed her. Staff #5 went up the road to make a u-turn. Staff #5 called Licensee #8/Director of Operations who told Staff #5 to follow Client #1 and call the police if needed. Staff #5 parked her car to get out and assist Staff #4. A community member had stopped and had called 9-1-1. Staff spoke with the police and identified themselves. Call to Licensee #7 was made for the police to speak with Licensee #7 and the decision was made to take Client #1 to the hospital. Client #1 was taken to the hospital by ambulance. Staff #4 returned to the group home and Staff #5 went to the hospital with Client #1. Client #1 was checked for signs of assault. The police remained at the hospital with Staff #5 and Client #1. The decision was made by the police to return Client #1 to the group home because there were no marks on Client #1. Client #1 refused to get into Staff #5's car to return to the group home so the police transported Client #1 to the group home. There were no further problems upon return to the group home.	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-648	A. BUILDING: ______ B. WING ______	09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TURN AROUND	**9709 BATTEN COURT MINT HILL, NC 28227**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	Continued From page 8	V 512		

Interview on 9/11/18 with the House Manager #6 revealed:
-Staff #4 and Staff #5 went to pick up Client #1 from school. The House Manager received a call from Licensee #8/Director of Operations informing her that Client #1 had jumped out of the car at a busy intersection and Staff #4 chased Client #1 to get back to the car. A community member had called the police. Client #1 was taken to a local hospital for evaluation and was discharged the same day. Client #1 was transported from the hospital to the group home by the police because she refused to get into Staff #5's car. There was no police report or injury to Client #1. The Department of Social Services investigated the incident. Client #1 has a history of property destruction and aggression, especially to Staff #4.

Interview on 9/11/18 with the Licensee #7 revealed:
-Did not have a copy of the police report completed on 9/4/18 regarding the incident involving Client #1 and Staff #4;
-Did not have any witness names and phone numbers regarding the incident involving Client #1 and Staff #4 because there was no police report as the call went through the 9-1-1 system;
-When the police arrived to the scene on 9/4/18, Client #1 was resistant to staff and police and they took her in an ambulance to behavioral health where she was assessed and released;
-The police did not complete a report because they knew Client #1 and her history of running away and aggression.

Interview on 9/11/18 with the Paralegal from the local Police Department Attorney's Office revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-648	A. BUILDING: ______ B. WING ______	09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TURN AROUND	9709 BATTEN COURT MINT HILL, NC 28227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	Continued From page 9	V 512		

-A 9-1-1 call was received on 9/4/18 regarding Client #1 and a police report was generated;
-Must legally request a copy of the report.

Interview on 9/24/18 with the Citizen #9 revealed:
-Saw Staff #4 hitting Client #1 in the face when Client #1 was being assaultive to Staff #4. Believed it to be a street fight between two high school students upon first witnessing the incident. After calling 9-1-1 and physically separating the two individuals later realized the incident was occurring between an adult woman and a child. "Seemed like excessive force toward the child." Staff #4 was holding the client by the hair and open-hand slapping Client #1 in the face. Client #1's face was red and puffy before the ambulance arrived. Staff #5 arrived on the scene after Staff #4 and Client #1 were separated;
-Was very emphatic about the details of what she witnessed and was equally concerned about the client's well-being.

Interview on 9/26/18 with the Licensee #8/Director of Operations revealed:
-Did not know that there was a police report generated after the 9/4/18 incident with Client #1;
-Was never told that there was a witness to the 9/4/18 incident with Client #1;
-Client #1 was sent to the hospital for evaluation after the 9/4/18 incident and was evaluated and released back to the facility with no injuries noted. Client #1 would never have been released into the care of the group home had Staff #4 actually hurt Client #1;
-Completed notification to HCPR and documentation of the incident through NC IRIS as required;
-Nobody ever informed Licensee #8/Director of Operations that Staff #4 had allegedly beat up Client #1;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-648	A. BUILDING: ______ B. WING ______	09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TURN AROUND	9709 BATTEN COURT MINT HILL, NC 28227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	Continued From page 10 -Client #1 never reported she got hit; -Did not talk with the witness; -Client #1 is a huge liability and the facility is the only place which will keep Client #1; -Staff #4 was moved from the facility after the investigation with DSS and DHSR (Division of Health Service Regulation); -We "did everything we can do as an agency with the information we have;" -The Group Home Manager spoke with the police; -The police never told Licensee #8/Director of Operations that any outside party reported Staff #4's actions; -DSS investigated and expressed concerns over Staff #4's safety; -Does not understand why DHSR did not interview the DSS investigator; -Client #1 expressed that she wants to kill Staff #4's unborn baby; -DSS has significant concerns with Client #1; -No safety concerns were ever expressed about Client #1 by the police or DSS; -"This (the Type A1 administrative action) is ridiculous;" -The community member (who witnessed the incident) may not know the entire situation with Client #1; -Client #1 had no marks on her (while being evaluated after the incident); -The police did not find any safety concerns and a witness is "all new information to me;" -"We didn't know about witnesses;" -Client #1 jumped out of the car and Staff #4 got out of the car to get Client #1. Staff #5 was talking with police and Licensee #8/Director of Operations called Client #1's DSS Social Worker who called the House Manager. The DSS Social Worker talked to the police involved in the incident but never called Licensee #8/Director of	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-648	A. BUILDING: ______ B. WING ______	09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TURN AROUND	9709 BATTEN COURT MINT HILL, NC 28227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	Continued From page 11	V 512		

Operations back with any information about the incident. Had an emergency team meeting and the group home will no longer transport Client #1. Client #1's DSS Social Worker never had any safety concerns;
-When anything happens with Client #1, Licensee #8/Director of Operations is careful to send everyone an email about the case;
-"I will print you the emails for your report."
-The police have dealt with Client #1 before;
-Tries to stay on top of all issues with Client #1.

Observation on 9/10/18 at approximately 3:10pm of Client #1 revealed:
-No visible marks or scratches on the client's neck, face, arms or hands.

Review on 9/26/18 of the Plan of Protection written by Licensee #8/Director of Operations dated 9/26/18 revealed:
"What will you immediately do to correct the above rule violations in order to protect clients form further risk or additional harm? Describe your plans to make sure the above happens.
The staff member was removed from the home. The staff no longer works with the consumer. New Place (Licensee) will provide immediate training to all staff members that have contact with the consumer to ensure they utilize least restrictive techniques and strategies to deescalate the consumer's behaviors. New Place will immediately apply for an enhanced rate from Vaya Health (Local Management Entity) to ensure a third staff can be present at all times to manage consumers behaviors. The staff member no longer works at the facility. New Place will provide additional staffing. New Place will transport consumer only when necessary with child locks activated."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-648	A. BUILDING: ______ B. WING ______	09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TURN AROUND	9709 BATTEN COURT MINT HILL, NC 28227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	Continued From page 12	V 512		

Upon request on 9/26/18 of Licensee #8/Director of Operations, the following will be documented in the report:
-Email chain initiated on 9/6/18 from Client #1's day treatment location expressing concern about being able to maintain Client #1 in the day treatment placement due to lack of authorization. Additional email from Licensee #8/Director of Operations identifying the incident of 9/4/18 explaining Client #1's attempt of running away and the response of the police and the concerns of the community member, as well as evaluation at a local hospital. Licensee #8/Director of Operations requested that Client #1 be allowed to ride the school bus. The DSS Social Worker from client's county of origin responded requesting additional services and funding or a 30 day discharge notice would be issued with the recommendation to have Client #1 return to a higher level of care with the plan of "getting Law Enforcement involved with charges for any future assaults, possibly opening the door for detention in the future."

Additional request on 9/26/18 of Licensee #8/Director of Operations, the following faxed information received on 9/27/18 will be documented in the report:
-Letter from Client #1's day treatment program dated 3/14/18 authorizing Medicaid transportation services beginning 3/12/18 through 5/31/18 through a local cab service;
-Level III Residential Note for Client #1 dated 3/20/18 completed by the Qualified Professional/Licensed Professional revealed: "Staff learned from support staff that consumer jumped out of a cab while being transported from a day treatment program to the group home (shortly after 2:00pm today). Staff learned from support staff that the cab driver followed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-648	A. BUILDING: ______ B. WING ______	09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TURN AROUND	9709 BATTEN COURT MINT HILL, NC 28227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	Continued From page 13 consumer on foot for approximately one mile before he was able to coax her into getting back in the cab. Staff learned that the cab driver allowed consumer to sit in the front passenger seat instead of the rear seat. Staff learned that consumer allegedly touched the cab driver inappropriately and her actions made him feel uncomfortable. Staff surmised that consumer is a risk to other people and a risk to herself as well (due to her impulsive nature and flighty behavior that often occurs when she is being transported in the community). Staff was aware that consumer is scheduled to have a child and family team meeting on 3-21-18 in order to address and discuss a lack of progress in managing her behavior over the past four weeks. Staff surmised that the team might recommend a higher level of care due to her risky and unsafe behavior as well as carrying out elopements from the group home and going in the community where she resorted to stealing from local department stores ...Consumer put her safety at risk today by impulsively going into oncoming traffic. Consumer also comprised the cab driver's safety by touching him inappropriately while he was driving and after she exited the vehicle as he pursued her on foot in order to protect her from getting injured on a heavily traveled street prior to rush hour ...;" - Level III Residential Note for Client #1 dated 6/6/18 completed by the Qualified Professional/Licensed Professional revealed: " ...Consumer previously complained that a representative from a local day treatment program pulled her hair (undetermined). Consumer became agitated and angry toward the end of the day (at the program). Consumer refused to get in a personal vehicle of a particular support staff. Consumer threatened to harm herself. Consumer exhibited negative attention	V 512		

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V 512	Continued From page 14	V 512		

seeking behavior. Consumer spoke with a particular New Place (Licensee) professional support even though she initially refused to do so. Consumer said she wasn't going to get in the vehicle. Consumer said she didn't want to return to the group home. Consumer struggled with calming down and listening to supportive adults. Consumer answered questions posed by a local police officer to resolve the matter. Consumer was convinced by New Place professional support to calm down, get in the vehicle and come to the office in order to pick up new clothes, sandals and other personal items. Consumer didn't seem to want to negotiate initially with supportive adults. Consumer saw a screen shot of the new items that had been purchased for her. Consumer agreed to get in the vehicle and come to the agency's office. Consumer agreed to follow directions and comply with reasonable request rather that becoming oppositional and throwing a temper tantrum when she didn't get her way or when she was told 'NO' ..."

Client #1 is a 12 year old child who is diagnosed with Attention Deficit Hyperactivity Disorder, Disruptive Mood Dysregulation Disorder, Post-Traumatic Stress Disorder, and Reactive Attachment Disorder. During an incident of attempted running away, Client #1 was abused by Staff #4 when Staff #4 sat on Client #1, pulled Client #1's hair and repeatedly hit Client #1 in the face resulting in Client #1's face being red and puffy. This deficiency constitutes a Type A1 rule violation for serious abuse and must be corrected within 23 days. An administrative penalty of $2,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of

Division of Health Service Regulation

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V 512	Continued From page 15 compliance beyond the 23rd day.	V 512		