STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL071-022	A. BUILDING: _____ B. WING _____	11/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A SPECIAL TOUCH, INC	5925 NC HIGHWAY 11 WILLARD, NC 28478

(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 November 5, 2018. The complaint was unsubstantiated (Intake #NC00144821). 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		

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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 record reviews and interviews the facility failed to report the allegation of client abuse to the Health Care Personnel Registry (HCPR) for 1 of 3 staff audited (Staff #13). The findings are: Review on 11/5/18 of Staff #13's personnel record revealed: -Position/Title: Residential Counselor -Date of Hire: 1/23/18 -North Carolina Interventions (NCI), A and B completed on 1/24/18. Review on 11/5/18 of client #1's record revealed: -16 year old male admitted 4/11/18. -Diagnoses included attention deficit hyperactive disorder (ADHD), combined type; moderate intellectual developmental disorder; pervasive depressive disorder. Interview on 11/5/18 client #1 stated: -He had lived at the facility about 1 year. -He did not feel safe because of staff and "kids."	V 132		

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V 132	Continued From page 2	V 132		

"Kids" would fight and "staff hurt me a lot."
-Staff #13 had hit him in the head 1 time. Staff #13 had shut the client's door and hit him because Staff #13 was mad. No one saw this happen and he (client #1) did not tell anyone at the facility it had happened.
-There were always 2 staff working.
-Before this happened he and Staff #13 got along well.

Telephone interview on 11/5/18 Staff #13 stated:
-He had been suspended since 10/31/18.
-On 10/30/18 there was an incident with client #1 getting "unruly, out of hand." Client #1's behavior was "moving toward a physical altercation with client #2."
-He "separated" the 2 clients by taking client #1 by his shirt and moving him to his room.
-He did not hit client #1.
-Staff #9 was also working the shift when the incident occurred, but he had stepped outside to the porch to make a phone call. He did not see this incident.

Interview on 11/5/18 Staff #9 stated:
-On 10/30/18 client #1 spilled some milk during dinner.
-When client #1 spilled the milk, staff directed him to get some towels and clean it up. Staff #13 was on duty and took the lead on telling client #1 what to do and assigning him the extra chores. He thought the extra chores were to sweep floor and dry dishes.
-Client #1 knew he was in trouble and he was sitting at the table and was calm.
-Staff #9 walked out to the trash can and when he came back inside he was told client #1 was in his room.
-Staff #9 was not aware any incident had occurred when he walked outside. Client #1

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V 132	Continued From page 3 never said anything about Staff #13 hitting him. -He had never seen any staff hit a client. Interview on 11/5/18 the Licensee stated: -Last week client #1 told his school counselor he had been hit on his head by Staff #13. The counselor called client #1's guardian, a County Department of Social Services (DSS), and a DSS Social worker notified the facility on 10/31/18. -The allegation was made to the school counselor on 10/31/18, therefore, it would have occurred on 10/30/18 on the 4 pm -12 am shift. Working on that shift was Staff #13 and Staff #9. -The Licensee and Qualified Professional (QP) met with client #1 when he returned from school on 10/31/18. -Staff #13 was put on administrative leave pending the investigation. -Client #1 had a history of making false allegations. He made at least 2 allegations against his former foster parent and that was why he was admitted to the facility. The DSS Social Worker reported this was typical behavior for client #1. -The Licensee did not think client #1 understood the seriousness of such allegations. -The Licensee and QP asked client #1 why he did not report to the other staff on duty when he was hit by Staff #13, and he responded, "I don't know." -An investigation was being completed by the QP and a consultant. -There had not been a report made to the HCPR.	V 132		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and	V 366		

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

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V 366	Continued From page 5 (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		

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V 366	Continued From page 6 Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement written policies governing their response to level 3 incidents as required. The findings are: Review on 11/5/18 of facility incident reports for October and November 2018 revealed no Level 3 reports for allegations of client abuse. Review on 11/5/18 of the facility incident reporting policy revealed allegations of abuse, neglect, and/or exploitation were not identified as Level 3 incidents. Interview on 11/5/18 the Licensee stated: -She had been made aware on 10/31/18 that client #1 reported to his school counselor that Staff #13 had hit him. -The Qualified Professional (QP) had conducted client and staff interviews regarding the incident. -A private consultant was completing an internal	V 366		

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V 366	Continued From page 7 investigation. -They were waiting until the investigation was completed to submit the IRIS (North Carolina Incident Response Improvement System) Report. -The Licensee was not aware allegations of abuse, neglect, and exploitation were Level 3 incidents. Interview on 11/5/18 the QP stated he was not aware allegations of abuse, neglect, and exploitation were Level 3 incidents. Refer to V132 for additional information.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident;	V 367		

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V 367	Continued From page 8 (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided	V 367		

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V 367	Continued From page 9 by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report level 3 incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are: Review of facility incident reports for October and November 2018 revealed no IRIS (North Carolina Incident Response Improvement System) reports for allegations of abuse. Interview on 11/5/18 client #1 stated he had been hit 1 time in the head by Staff #13. Interview on 11/5/18 the Licensee stated: -She and the Qualified Professional (QP) had been made aware on 10/31/18 that client #1 reported to his school counselor that Staff #13	V 367		

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V 367	Continued From page 10 had hit him. -An internal investigation was in process. -Their plan was to submit the IRIS report once the investigation was completed. Refer to V132 and V366 for additional information.	V 367		
V 521	27E .0104(e9) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (9) Whenever a restrictive intervention is utilized, documentation shall be made in the client record to include, at a minimum: (A) notation of the client's physical and psychological well-being; (B) notation of the frequency, intensity and duration of the behavior which led to the intervention, and any precipitating circumstance contributing to the onset of the behavior; (C) the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used; (D) a description of the intervention and the date, time and duration of its use; (E) a description of accompanying positive methods of intervention; (F) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of	V 521		

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restrictive interventions;
(G) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and
(H) signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to document restrictive interventions as required affecting 2 of 2 current clients audited (clients #1, #2), and 1 of 1 former clients (FC), (FC#4) audited. The findings are:

Finding #1:
Review on 11/5/18 of FC#4's record revealed:
-14 year old male admitted 6/8/18 and discharged 10/24/18.
-Diagnoses included Disruptive Mood Dysregulation Disorder.
-No documentation in FC#4's record of restrictive interventions on 8/20/18.

Review of facility incident report dated 8/20/18 revealed:
-At approximately 2 am FC#4's punched holes in the walls and eloped.
-Police were called and staff pursued the client.
-FC#4's was restrained "standing" for 3 minutes.

Finding #2:
Review on 11/5/18 of client #1's record revealed:
-16 year old male admitted 4/11/18.
-Diagnoses included Attention Deficit Hyperactive Disorder (ADHD), combined type; Moderate Intellectual Disabilities; Pervasive Depressive

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V 521	Continued From page 12 disorder. -No documentation in the client #1's record of restrictive interventions on 10/30/18. Review of facility incident reports from 8/1/18 - 11/4/18 revealed no report of a restrictive intervention on 10/30/18. Telephone interview on 11/5/18 Staff #13 stated: -There was an incident on 10/30/18 with client #1 during dinner. -Client #1 was getting "unruly, out of hand." His behaviors were "moving toward a physical altercation with client #2." Staff #13 "separated" the 2 clients by taking client #1 by his shirt and moving him to his room. Finding #3: Review on 11/5/18 of client #2's record revealed: -15 year old male admitted 11/2/17. -Diagnoses included Disruptive Mood Disorder. -No documentation in client #2's record of restrictive interventions on 8/20/18. Review of facility incident report dated 8/20/18 revealed: -On 8/20/18, "at approximately 2 am" client #2 had been restrained for approximately 3 minutes for aggressive behavior toward staff. Interview on 11/5/18 the Qualified Professional (QP) stated: -Staff would write up a "narrative" for restrictive interventions and the Licensee entered the information into IRIS (North Carolina Incident Response Improvement System). -QP reviewed staff's documentation of the restrictive intervention. -QP would debrief with the consumer. -Staff #13's actions on 10/30/18 in response to	V 521		

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V 521	Continued From page 13 client #1's behaviors were not an appropriate restrictive intervention. -After review of required documentation of restrictive interventions in regulations, the QP stated all of the requirements were not routinely documented by staff. -QP stated he would develop a documentation process to help staff document what is required for restrictive interventions.	V 521		
V 525	27E .0104(e17) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (17) The facility shall conduct reviews and reports on any and all use of restrictive interventions, including: (A) a regular review by a designee of the governing body, and review by the Client Rights Committee, in compliance with confidentiality rules as specified in 10A NCAC 28A; (B) an investigation of any unusual or possibly unwarranted patterns of utilization; and (C) documentation of the following shall be maintained on a log: (i) name of the client; (ii) name of the responsible professional; (iii) date of each intervention; (iv) time of each intervention; (v) type of intervention; (vi) duration of each intervention; (vii) reason for use of the intervention; (viii) positive and less restrictive alternatives that were used or that were considered but not	V 525		

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V 525	Continued From page 14 used and why those alternatives were not used; (ix) debriefing and planning conducted with the client, legally responsible person, if applicable, and staff, as specified in Parts (e)(9)(F) and (G) of this Rule, to eliminate or reduce the probability of the future use of restrictive interventions; and (x) negative effects of the restrictive intervention, if any, on the physical and psychological well-being of the client. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain documentation in a log of restrictive interventions to include all required information. The findings are: Review of facility incident reports between 8/1/18 and 11/4/18 revealed: -8/20/18 former client (FC) #4 had been restrained for 3 minutes due to aggressive behaviors. -8/20/18 client #2 had been restrained for 3 minutes due to aggressive behaviors. Interview on 11/5/18 the Licensee stated: -There was no restrictive intervention log that documented the required information. -She was not aware a log was required for restrictive interventions.	V 525		
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	V 537		

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V 537	Continued From page 15 been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service 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);	V 537		

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V 537	Continued From page 16 (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence 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.	V 537		

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V 537	Continued From page 17 (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (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	V 537		

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V 537	Continued From page 18 outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews, 1 of 3 staff audited failed to demonstrate competency in the application of a physical restraint (Staff #13). The findings are: Review on 11/5/18 of Staff #13's personnel record revealed: -Position/Title: Residential Counselor -Date of Hire: 1/23/18 -North Carolina Interventions (NCI), A and B completed on 1/24/18. Telephone interview on 11/5/18 Staff #13 stated: -He had been suspended since 10/31/18. -On 10/30/18 there was an incident with client #1 getting "unruly, out of hand." Client #1's behavior was "moving toward a physical altercation with client #2." -He "separated" the 2 clients by taking client #1 by his shirt and moving him to his room.	V 537		

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V 537	Continued From page 19 -He did not hit client #1. -Staff #9 was also working the shift when the incident occurred, but he had stepped outside to the porch to make a phone call. He did not see this incident. Interview on 11/5/18 Staff #9 stated: -On 10/30/18 client #1 spilled some milk during dinner as a result of horseplay. Client #1 has good days and some bad days and can "flip like a switch" if told to do something and he becomes non compliant. -Staff directed client #1 to calm down, but he would not stop playing. -When client #1 spilled the milk, staff directed him to get some towels and clean it up. Staff #13 was also on duty and took the lead on redirecting client #1 and assigned him extra chores as a consequence. He thought the extra chores were to sweep the floor and dry dishes. -Client #1 knew he was in trouble and sat at the table and was calm. -Staff #9 walked out to the trash can. When he returned he was told client #1 was in his room. -Staff #9 was not aware any incident had occurred when he walked outside. -Staff were properly trained in restrictive interventions and he had never seen an inappropriate restrictive interventions. Interview on 11/5/18 the Qualified Professional stated: -He met with Staff #13 after he learned client #1 made the allegation that Staff #13 hit him. -Staff #13 reported all clients were at the table eating dinner when client #1 spilled another consumer's milk. Client #1 refused to clean up the spilled milk. Client #1 was directed to clean his plate and go to his room in an effort to get him to "cool off." Staff #13 stated client #1 was	V 537		

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V 537	Continued From page 20 "mouthing," non-compliant, and would not follow directions. Then Staff #13 tugged on client #1's shirt sleeve, and "pulled" him toward his room. -The QP informed Staff #13 this was not appropriate. -Staff were taught therapeutic walks and restrictive interventions, and this was not how they were taught. -The other staff on duty, Staff #9, was interviewed and stated he did not see this incident because it happened when he took out the trash.	V 537		