

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL049-119</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>01/14/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>BARIUM SPRINGS HOME FOR CHILDREN - KING HOI</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>138 BARIUM SPRINGS DRIVE STATESVILLE, NC 28677</b>		
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V 000	<b>INITIAL COMMENTS</b>  An annual and complaint survey was completed on 1/14/2019. Three of the complaints were unsubstantiated (intake #NC146357, NC146866 and NC146974), and one was substantiated (intake #NC147124). Deficiencies were cited.  This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents.	V 000		
V 537	<b>27E .0108 Client Rights - Training in Sec Rest &amp; ITO</b>  10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based,	V 537	<b>27E .0108 Client Rights- Training in Sec Rest &amp; ITO</b>  All PRTF staff will be trained on definition/clarification of restraints. This will include notification of supervisory staff for when hands are placed on youth, incident report requirements and restraint protocol.  TCI training refresher will be completed for all PRTF staff focusing on proper techniques using examples of restraints that were cited.  Video will be reviewed of any physical interventions by TCI Instructor (Program Manager or Residential Director. All video reviews to be submitted to Director and CPO for review until competency can be displayed.  Video review form will be created and Program Coordinator will track completion of video reviews and provide weekly summary of trends and patterns.  Video review will be incorporated into debrief process. Instructor will identify any concerns with not utilizing proper TCI techniques and immediate retraining will occur if techniques are not correct until competency can be displayed.  Patterns and trends will be identified and incorporated into TCI Trainings.	1/16/2019  2/8/2019  On-going  1/21/2019  On-going  1/16/2019

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

47UE11

LICENSING SPECIALIST

1/22/2019

If continuation sheet 1 of 25

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DHSR-MH Licensure Sect

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V 537	Continued From page 1  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 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:	V 537	Summary report to be reviewed by ELT every 30 days until competency can be displayed.  Scheduled service delivery of Program Manager Director, Clinical Director, TFC Manager, Lead Consultant and CPO will monitor for compliance with TCI techniques and restraint protocols.  Individual Staff Concerns:  BM: upon notification of concerns about restraint, footage was reviewed by Program Manager and Senior Director of Compliance. Staff was suspended, retrained, and EAP referral made. Increased supervision of him on shift by Program Manager, Director, TFC Manager, Lead Consultant and CPO. Will suspend his training of TCI for next 90 days to focus on retraining.  TD: performance correction based on review of restraining. TCI Retraining to be completed.  JS: performance correction based on review of restraining. TCI Retraining to be completed.	On-going  On-going    1/14/2019   1/30/2019  1/30/2019

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V 537	Continued From page 2  (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. (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	V 537		

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STATE FORM

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V 537	Continued From page 4  interviews, the facility failed to ensure facility staff demonstrated competence in the proper use of physical restraints and procedures affecting 3 of 6 audited staff (Child Youth Care Worker (CYCW) #1, CYCW #2 & the Consultant/Therapeutic Crisis Intervention (TCI) Instructor (C/TCII)). The findings are:  Finding #1: Review on 1/2/19 of client #5's record revealed: -Admission date: 11/5/18; -Diagnoses included Dissociative Identity Disorder, Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder and Insomnia; -Age: 10 years old; -An assessment dated 11/9/18 revealed: -The client was of "average height and overweight;" -The client's grandmother acquired custody when he was 4-5 months old; -A medical exam dated 11/9/18 included: -"Grandmother reports he has heard voices in his head for several years and has also had mood swings/personality changes;" -"He was present for grandmother's suicide attempt in October 2017 and then experienced physical/emotional abuse while in the care of his mother for several months in early 2018;" -A Behavior Support Plan dated 11/27/18 revealed: -"History of being restrained, feeling suicidal, physical abuse, physical aggression, running away, suicide attempt and self-harm;" -"Triggers included instructions from adult, getting a no answer, arguments, being isolated, being called names or teased, feedback, feeling threatened, loud noises, people in uniform, people too close, seeing other in crisis, consequences for behavior, mornings, yelling,	V 537		On-going  n-going

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V 537	<p>Continued From page 5</p> <p>and death."</p> <p>Interview on 1/4/19 with client #5 revealed:</p> <ul style="list-style-type: none"> <li>- On 12/7/18, the C/TCII "slammed me on my back;"</li> <li>- "Like he picked me up;"</li> <li>- "He was behind me and picked me up by my stomach."</li> </ul> <p>Review on 1/2/19 of the C/TCII's employee record revealed:</p> <ul style="list-style-type: none"> <li>- A hire date of 9/12/16;</li> <li>- A job title of Consultant;</li> <li>- Training on "Identifying and Preventing Child Abuse and Neglect" on 10/7/16, 9/15/17 &amp; 8/17/18;</li> <li>- Therapeutic Crisis Intervention (TCI) Trainer Associate certification was valid from 2/3/17 - 2/2/19.</li> </ul> <p>Review on 1/7/19 of a video dated 12/7/18 revealed:</p> <ul style="list-style-type: none"> <li>- The time stamp of the video was from 2:00:00 pm (hour: minute: second) to 2:25:38 pm</li> <li>- Two camera views were recorded: both from the north common area;</li> <li>- At 2:15:07, client #5 was walking towards the C/TCII, who was walking backwards;</li> <li>- At 2:15:31, client #5 and the C/TCII were talking in front of the window looking out towards the back fenced in area;</li> <li>- At 2:15:56, the C/TCII walked around the client and the client began walking in the opposite direction;</li> <li>- At 2:16:02, the client turned around and began walking toward the CC/TCII with his fists balled up;</li> <li>- At 2:16:10, the C/TCII pushed the client's chest with his left arm;</li> <li>- At 2:16:13, the client pushed the C/TCII with his</li> </ul>	V 537			

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V 537	<p>Continued From page 6</p> <p>right arm;</p> <p>-At 2:16:15, the C/TCII pushed the client's chest with his left arm;</p> <p>-At 2:16:24, the client swings at the C/TCII;</p> <p>-At 2:16:31, the C/TCII pushed the client in the face with his left arm;</p> <p>-At 2:16:35, the C/TCII held up his left arm and the client smacked it away;</p> <p>-At 2:16:51, the client leaned towards the C/TCII and the staff pushed him on his chest with his left arm;</p> <p>-At 2:16:52, the client grabbed the C/TCII's arm;</p> <p>-At 2:16:53, the C/TCII grabbed the client around his head with both arms and took 2 steps forward, forcing the client to the ground while 2 other staff watched;</p> <p>-At 2:16:58, one of the observing staff grabbed the client's right arm and the C/TCII grabbed the client's left arm;</p> <p>-At 2:17:03, the other staff that observed the incident grabbed the client's legs;</p> <p>-The nurse approached with her cellular telephone at 2:17:19;</p> <p>-At 2:17:35, another staff took over holding the client's legs;</p> <p>-The client remained in a supine restraint during the rest of the video.</p> <p>Interview on 1/4/19 with client #4 revealed he had never been inappropriately restrained by the C/TCII but he had "slammed other kids."</p> <p>Interview on 1/4/19 with CYCW #1 revealed:</p> <p>-The C/TCII moved quickly when he restrained the clients;</p> <p>-"He's come out of the kitchen and tackled kids;"</p> <p>Interviews on 1/4/19 and 1/8/19 with the C/TCII revealed:</p> <p>-On 12/7/18, "I was in a CFT (Child and Family</p>	V 537			

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V 537	<p>Continued From page 7</p> <p>Team) meeting with another client;"</p> <p>- "I stepped out on the floor to see what was going on;"</p> <p>- "He (client #5) was coming towards me in an aggressive manner;"</p> <p>- "I stuck my hand out;"</p> <p>- "He grabbed my arm and started twisting it;"</p> <p>- "I had my right hand on his back;"</p> <p>- "As soon as I got hold of him he pretty much fell backwards;"</p> <p>- "On the way to the ground, I guided him to the ground;"</p> <p>- "During the restraint, we were on the way down to the ground and my knee hit the ground;"</p> <p>- "I ended up doing it (restraint) by myself because the other staff didn't come in;"</p> <p>- "There was a staff person to my left but she didn't go in when I did;"</p> <p>- The C/TCII said "restraint" but thought the other staff didn't hear him;</p> <p>- "We're supposed to (restraint) initiate it quick;"</p> <p>- A supine restraint was better for the client rather than a small child restraint because the client struggled to breathe while in a small child restraint;</p> <p>- The Program Manager/TCI Instructor (PM/TCII) reviewed the video of the restraint with him and they discussed different alternatives which included: not getting backed into a corner, to continue to block and move rather than initiate a restraint, to step off the floor if he was the threat or the aggravating factor and make sure the staff were clear that a restraint was going to begin.</p> <p>Interview on 1/4/19 with the Residential Unit Supervisor revealed:</p> <p>- She had observed a restraint initiated by the C/TCII with client #5 that was inappropriate;</p> <p>- "It was more of a wrestling move;"</p> <p>- "It didn't look like we were trained to do;"</p>	V 537		



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V 537	<p>Continued From page 8</p> <p>- "Even when he (C/TCII) was doing the training, it was different from what he did;"</p> <p>- "He (C/TCII) put him (client #5) down and grabbed an arm;"</p> <p>- The C/TCII should have communicated with the other staff present what was going to happen and what they needed to do to assist;</p> <p>- "It was unacceptable."</p> <p>Interviews on 1/3/19 and 1/8/19 with the PM/TCII revealed:</p> <p>- She had reviewed the video of the restraint that the C/TCII initiated with client #5;</p> <p>- "It was not a pretty restraint;"</p> <p>- The C/TCII was in a corner and did not have enough space to initiate the restraint appropriately;</p> <p>- The C/TCII initiated the restraint by himself;</p> <p>- "The restraint he was trying to do (supine restraint) was not a one person restraint;"</p> <p>- She had retrained the C/TCII and provided feedback which included: switching places with another staff when he was the target, communicating better with staff and the proper way to do a supine and small child restraint.</p> <p>Review on 1/9/19 of the TCI Training Manual regarding proper steps of the supine restraint revealed:</p> <p>- "Approach the young person from the front and with his/her outside hand, grasp the young person's arm just above the wrist;"</p> <p>- "Bring the young person's arm across the plane of the staff's body and securely hold it against him/her;"</p> <p>- "Bring his/her hips tight against the young person and place the heel of his/her inside foot against the heel of the young person;"</p> <p>- "Take a step forward with his/her outside leg and drop down to his/her knee;"</p>	V 537			

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V 537	<p>Continued From page 9</p> <p>- "Lower the young person to the floor and take his/her hand yoked under the young person's arm and place it on the shoulder of the young person."</p> <p>Review on 1/3/19 of the Incident Response Improvement System (IRIS) revealed: - Date of the 12/7/18 incident report review: 12/20/18; - Summary of Findings: "Based on review of video footage and interview with TCI instructor, it appears that staff did not use proper TCI techniques when conducting a restraint on client."</p> <p>Review on 1/2/19 of the facilities record of submitted Health Care Personnel Registry (HCPR) reports for the months of November and December 2018 revealed: - An internal investigation was completed regarding the allegation of an improper restraint initiated by the C/TCII with client #5; - A finding of substantiated was entered into IRIS on 12/15/18.</p> <p>Finding #2: Review on 1/2/19 of client #1's record revealed: - Admission date: 11/19/18 - Diagnoses: Schizophrenia, in Partial Remission; Oppositional Defiant Disorder; and Attention Deficit-Hyperactivity Disorder (ADHD); - Age: 12 - An assessment dated 11/19/18 revealed a history of 3 psychiatric hospitalizations and out of home placements since March of 2018, not listening or following directions, and a social history of parent not being able to work due to the time required to deal with client #1's issues; - CFT meeting notes dated 11/19/18 to 11/28/18 noted a history of suicidal ideation, "I can't sleep and my parents think I am masturbating all the time," inappropriate sexual behavior, physical</p>	V 537			

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V 537	<p>Continued From page 10</p> <p>abuse, physical aggression, running away, sexual abuse, verbal aggression, threats to self-harm without actual harm, and "odd" behaviors which worsened Spring of 18 (paranoia, threatening self and others, repetitive speech, talking about random topics, "lives in her own world"), which resulted in hospitalizations;</p> <p>- A treatment plan dated 11/13/18 listed goals related to 1) learning triggers of anxiety, stress, overwhelming feelings of loss and honestly and effectively manage symptoms by employing coping skills, utilizing and implementing distress tolerance techniques, and engaging in positive peer relations through social skill development, and 2) actively participate in all aspects of treatment, assessments and maintain compliance with all Diversion and Assessment Program (DAP) requirements to include participation and compliance with group home expectations such as engaging in daily routines, following house rules, participating in therapy, respecting adult authority figures, and interacting with peers without verbal altercations.</p> <p>Further review on 1/9/19 of client #1's record revealed:</p> <p>- A residential progress note dated 12/11/18 noted " ... Staff constantly redirects client and give her directive statements for making inappropriate comments about the therapist ..."</p> <p>- No documentation was present related to CYCW #1 physically carrying client #1 away from the Therapist's office door.</p> <p>Review on 1/2/19 of CYCW #1's employee record revealed:</p> <p>- Hire date: 2/16/18</p> <p>- Training on "Identifying and Preventing Child Abuse and Neglect" on 3/1/18, 6/3/18 &amp; 10/21/18;</p> <p>- Training in TCI on 11/14/18.</p>	V 537		

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V 537	<p>Continued From page 11</p> <p>Review on 1/2/19 of the facility's incident reports revealed:</p> <ul style="list-style-type: none"> <li>- On 12/9/18, client #1 was caught attempting to write "an inappropriate, sexually explicit letter" for the Therapist, followed by client #1 making a threat to "beat her (the Therapist) unconscious and rape her ..."</li> <li>- There was not an incident report for the incident on 12/11/18 in which CYCW #1 physically carried client #1 away from the Therapist's office door.</li> </ul> <p>Review on 1/7/19 of a video dated 12/11/18 revealed:</p> <ul style="list-style-type: none"> <li>- The time stamp of the video was from 12:05:56 pm (hour: minute: second) to 12:06:59 pm;</li> <li>- No audio feed was available.</li> <li>- Three camera views were recorded: one from the "King Common 360 South" camera, and the other two from different distances on the "King South End Hall" cameras;</li> <li>- Client #1 was sitting on the floor in front of the Therapist's office door, and at times hit the door with the back of her right elbow;</li> <li>- CYCW #1 was standing in the hallway near client #1;</li> <li>- At 12:06:38, CYCW #1 reached down and grabbed client #1's left upper arm with her right hand and began pulling her away from the door;</li> <li>- At 12:06:43, CYCW #1 reached down with her left hand and repositioned client #1, who was on her knees, into a hold in which CYCW #1 held client #1's right upper arm with her right hand, client #1's left upper arm with her left hand, with CYCW #1 behind client #1's back;</li> <li>- CYCW #1 then lifted client #1 off the floor and began carrying her toward the common area in the middle of the building;</li> <li>- At 12:06:47, client #1 was placed on her feet and continued to be escorted to the common</li> </ul>	V 537		

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V 537	<p>Continued From page 12</p> <p>area and placed in a chair and released at 12:06:53;</p> <ul style="list-style-type: none"> <li>- Client #1 remained in the chair with CYCW #1 standing beside her through the rest of the video clip.</li> </ul> <p>Interview on 1/4/19 with client #1 revealed:</p> <ul style="list-style-type: none"> <li>- On 12/11/18, she had been sitting in front of the Therapist's closed office door;</li> <li>- CYCW #1 had repeatedly asked her to move away from the door, but client #1 declined to do so;</li> <li>- CYCW #1 had grabbed client #1 by the right arm to move her away from the door;</li> <li>- She was not injured when CYCW #1 carried her to the common area.</li> </ul> <p>Interview on 1/4/19 with CYCW #1 revealed:</p> <ul style="list-style-type: none"> <li>- On 12/11/18, client was sitting in front of the Therapist's office door;</li> <li>- " ... There's an issue going on between her and the Therapist. If they (clients) don't live on a certain hallway (the Therapist's office was located on a different hallway than the one client #1's bedroom was on) ...I did put hands on and try to get her off the hallway. I got behind her and lifted her up and she did baby legs (legs bent) and I had to move her ..."</li> <li>- CYCW #1 had moved 1 or 2 steps up the hall carrying client #1 before client #1 put her feet on the floor;</li> <li>- The C/TCII had told facility staff to prevent client #1 from lingering around the Therapist's office;</li> <li>- She had observed the C/TCII move client #1 away from the Therapist's door but using a "body block" type move a couple of days prior to the incident on 12/11/18;</li> <li>- CYCW #1 did not complete an incident report regarding the incident because it slipped her mind.</li> </ul>	V 537			

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V 537	<p>Continued From page 13</p> <p>Interviews on 1/4/19 and 1/8/19 with the C/TCII revealed:</p> <ul style="list-style-type: none"> <li>- His role at the facility included observation, monitoring, and giving feedback to facility staff;</li> <li>- The Consultant/TCI Instructor had not been present at the time of the incident on 12/11/18;</li> <li>- He had never given permission for facility staff to move client #1 away from the Therapist's door;</li> <li>- Facility staff were allowed to stand between a client and the door to block access;</li> <li>- The C/TCII had intervened once with client #1 to get her to move away from the Therapist's office by repeatedly encouraging her to move, but had not physically moved her himself;</li> <li>- "In TCI, we are not allowed to transport. We do not teach transport."</li> </ul> <p>Interviews on 1/3/19 and 1/8/19 with the PM/TCII revealed:</p> <ul style="list-style-type: none"> <li>- The PM/TCII had only learned of the incident on 12/11/18 on 1/3/19;</li> <li>- "... So in TCI it tells us that we can take up to 10 steps ... If a kid is in the road we can take the 10 steps and get them safely out of the road ..."</li> <li>- A "performance corrective" action would likely be taken with CYCW #1 related to the incident on 12/11/18.</li> </ul> <p>Finding #3: Review on 1/2/19 of client #4's record revealed:</p> <ul style="list-style-type: none"> <li>- Admission date: 10/1/18</li> <li>- Diagnoses: Major Depressive Disorder, Recurrent, Severe; ADHD; and Disruptive Mood Dysregulation Disorder;</li> <li>- Age: 13</li> <li>- An assessment dated 9/13/18 revealed a history of inpatient treatment in May of 2018 due to suicidal thoughts, and the precipitant for the</li> </ul>	V 537		

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V 537	<p>Continued From page 14</p> <p>current admission being an argument with father, refusal to take medication, and cutting himself with the jagged edge of a broken pencil in the hopes that he would die;</p> <p>- A Comprehensive Clinical Assessment dated 10/5/18 noted a history of tantrums, repetitiveness, fixating on information, tearfulness, argumentativeness, property destruction, running away, impulsivity, poor decision making, low self-esteem, immaturity, manipulation, hoarding food, overeating, poor social skills, hypersensitivity, and dependency;</p> <p>- CFT meeting notes dated 8/14/18 to 10/8/18 noted a history of physical aggression, suicidal ideation and attempts, verbal aggression, self-harm by cutting, and escalating depression;</p> <p>- A treatment plan dated 10/15/18 listed goals related to 1) increase better communication and relationship with family by being more open to communicating, respecting personal space and listening to others, 2) demonstrate improved anger management skills, by regular practice of pro-social assertiveness in expressing feelings as well as ability to benefit from and make use of feedback about such self-expression, and 3) increase his ability to self-regulate escalation of anger and anxiety ... as evidenced by identifying emotions, independently communicating emotions with a calm voice tone to others, independently utilizing coping skills to reduce heightened emotion, a decrease in self-harm, decrease in verbal and physical aggression.</p> <p>Review on 1/2/19 of CYCW #2's employee record revealed:</p> <p>- Hire date: 10/16/17;</p> <p>- Training on "Identifying and Preventing Child Abuse and Neglect" on 11/4/17 &amp; 11/8/18;</p> <p>- Training in TCI on 11/13/18.</p>	V 537		

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V 537	<p>Continued From page 15</p> <p>Review on 1/2/19 of the facility's incident reports revealed:</p> <ul style="list-style-type: none"> <li>- There was not an incident report for the incident on 12/13/18 in which CYCW #2 physically pulled client #4 out of his bedroom;</li> <li>- There was an incident dated 12/13/18 at 6:30 pm in which client #4 had wrapped a sock around his neck and made statements that he wanted to die.</li> </ul> <p>Interview on 1/4/19 with client #4 revealed:</p> <ul style="list-style-type: none"> <li>- He reported that CYCW #2, "grabbed me by the arm and pulled me out of the room."</li> <li>- He further reported when he was pulled out of the room by CYCW #2 "my wrist popped."</li> <li>- He reported that he was not seen afterwards by the nurse.</li> <li>- "After that (being pulled out of his room by CYCW #2) I had a mental break down. I was sitting there cussing, just freaking out because one of my friends here, she's a girl, she was putting me into an emotional spiral. I'm still fixing that problem. "</li> </ul> <p>Interview on 1/7/19 with CYCW #2 revealed:</p> <ul style="list-style-type: none"> <li>- At the beginning of the interview, he could not recall dragging or pulling client #4 out of his room on 12/12/18 or 12/13/18;</li> <li>- CYCW then stated, "The days run together. He (client #4) was trying to harm himself. He's in the very, very end (his bedroom is at the end of the hall). He was in there (bedroom), I think he was hitting his fist on the wall. I just guided him out of the room so I could get some help."</li> <li>- CYCW #2 had "guided" client #4 out of his bedroom by holding client #4's upper arms and walking behind him;</li> <li>- CYCW #2's intent had been to move client #4 into an area where there were cameras and where he could get help from other staff;</li> </ul>	V 537		



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V 537	<p>Continued From page 16</p> <ul style="list-style-type: none"> <li>- CYCW #2 did not place client #4 into a physical restraint or pull him from the bedroom;</li> <li>- Client #4 was "very emotional" and had a history of attempting to harm himself by wrapping the string from sweatpants around his own neck;</li> <li>- "... We try to do everything to keep from restraining them (clients) ..."</li> </ul> <p>Interview on 1/7/19 with the Nurse revealed:</p> <ul style="list-style-type: none"> <li>- She was not told by facility staff that Client #4 had been restrained or pulled out of his bedroom by CYCW #2 on 12/13/18;</li> <li>- Following the incident on 12/13/18 in which client #4 had wrapped a sock around his neck, the Nurse was told by client #4 that, "...one of things that upset him (client #4) was he was pulled out of the room (by CYCW #2)."</li> <li>- "It is hard to effectively process with clients because of everything that is going on and I am unsure if the sock incident would have happened if the staff had done things the way they are supposed to."</li> </ul> <p>Interview on 1/3/19 with the PM/TCII revealed:</p> <ul style="list-style-type: none"> <li>- She was not aware of CYCW #2 pushing/dragging client #4 out of his bedroom until the day of her interview.</li> <li>- "That's a part of our other internal investigation that I was informed of today. I have to review cameras as well for that. It was more so that he (CYCW #2) had done a restraint with [client #4]."</li> </ul> <p>Finding #4: See finding #1 for client #5's record review.</p> <p>See finding #3 for CYCW #2's employee record review.</p> <p>Review on 1/7/19 of a video dated 1/7/19</p>	V 537		

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V 537	<p>Continued From page 17</p> <p>revealed:</p> <ul style="list-style-type: none"> <li>- The time stamp of the video was from 4:21: 52 pm (hour: minute: second) to 4:35:38 pm on 1/6/19.</li> <li>- Four camera views were recorded: one from the "King Common 360 South" camera (inside view of the common area), "King Rear Door Yard" camera (outside), "King Common 360 Back Dr." camera (inside with a view of back door and windows), and "King North Common Area" camera (inside with view of the common area).</li> <li>- At 4:21:01 pm CYCW #2 walked behind client #5 who is approaching the outside back door.</li> <li>- At 4:21:07 from inside camera view of double windows. CYCW #2 walked behind client #5 while holding client #5's arms behind his back.</li> <li>- At 4:21:33 pm client #5 is on the ground at the doorway to the common area. CYCW #2 used a slight kicking motion with his leg to push client #5 through the doorway to the common area.</li> <li>- At 4:21:50 pm while client #5 was laying on the ground, CYCW #2 pulled client #5 by his left arm away from the doorway.</li> <li>- At 4:21:53 pm Client #5 is on his back in the common area. Client #5 rolled around on the floor and kicked with his feet up in the air.</li> <li>- At 4:21:54 pm Client #5 punched at CYCW #2's leg. CYCW #2 started a supine restraint with 2 other staff members and the nurse observed the restraint.</li> <li>- At 4:34:57 pm client #5 was released from restraint. Client #5 hit at staff while he sat on the floor but quickly calmed down, got up and walked away from common area at the end of the video.</li> </ul> <p>Review on 1/9/19 of "PRTF Restraint Order Form" dated 1/6/19 revealed:</p> <ul style="list-style-type: none"> <li>- The form was completed by the nurse on client #5 when he was restrained by CYCW #2 on 1/6/19.</li> </ul>	V 537			

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V 537	<p>Continued From page 18</p> <ul style="list-style-type: none"> <li>- "Restraint Initiated at 1620 (4:20 pm) and MD notified."</li> <li>- "Restraint completed at 1634 (4:34 pm).</li> <li>- "[Client #5] released from restraint at 4:34 (pm). [Client #5] was still angry and refused vitals after being asked several times. No complications observed from restraint upon assessment, no pain reported. [Client #5] observed taking nap shortly afterwards."</li> </ul> <p>Interview on 1/7/19 with CYCW #2 revealed:</p> <ul style="list-style-type: none"> <li>- He was outside with client #5 on 1/6/19 and had asked client #5 to move to a different area.</li> <li>- When client #5 got in the faces of other clients he told client #5, "Let's go inside."</li> <li>- Client #5 was not cooperative and kicked him and told CYCW #2 "I hate you."</li> <li>- "I was holding him trying to get my keys out and he fell when the nurse and someone else was coming outside. I was just trying to guide him inside. I slid him around. Well, the door closed and I wanted to get him inside to keep the other kids from coming in on him. When they're kicking or hitting, you're doing your best to not get hit. That was just me trying to keep him from getting hurt. After she gave him a shot, he still didn't calm down. I didn't kick him."</li> </ul> <p>Interview on 1/7/19 with the Nurse revealed:</p> <ul style="list-style-type: none"> <li>- She was aware that CYCW #2 did an inappropriate restraint with client #5.</li> <li>- "... there was one (restraint) yesterday (1/6/19) not done correctly by [CYCW #2]. It was done with [client #5]. It was done at 4:20 pm and started outside and then came inside."</li> <li>- "When they were bringing him (client #5) in the building protocol was not followed. With TCI if you can't do it by yourself (you should) communicate with your peers if you need help with a restraint and that is important in a fight</li> </ul>	V 537			

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V 537	<p>Continued From page 19</p> <p>break up and I don't think it was followed (yesterday)."</p> <p>- "[CYCW #2] was taking his leg and pushing [client #5] inside the door. You don't pull by an arm or push a client by your foot. That's inappropriate according to TCI protocol."</p> <p>Interview on 1/9/19 with the Chief Program Officer for Residential Services (CPO) revealed:</p> <ul style="list-style-type: none"> <li>- The CPO had reviewed the video of the C/TCII "body slamming" client #5;</li> <li>- A decision was made to make an Employee Assistance Program referral, retrain, and temporarily suspend the C/TCII's training duties rather than terminate employment;</li> <li>- The CPO had not been aware of the incidents with CYCW #1 and CYCW #2 until it was brought to her attention by the Surveyors;</li> <li>- The facility was in the process of investigating the incidents with CYCW #1 and CYCW #2.</li> </ul> <p>Review on 1/9/19 of the Plan of Protection dated 1/49/19 written by the Residential Director revealed:</p> <ul style="list-style-type: none"> <li>- What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm?</li> </ul> <p>"All PRTF staff training on definition/clarification of restraint. Including notification of supervisory staff of hands are placed on youth and incident report requirements to be completed by 1/14/19. Training will occur with each shift directly when they are on shift. Video review of any physical intervention by Therapeutic Crisis Intervention (TCI) Instructor (Program Manager or Residential Director) Video review will be incorporated into debrief process. Instructor will identify any concerns with not utilizing proper TCI techniques and immediate retraining will occur if techniques are not correct. Patterns and trends will be</p>	V 537		

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V 537	<p>Continued From page 20</p> <p>identified and incorporated into TCI training. Performance concerns will be flagged for Director and Chief Program Officer (CPO) action. Implemented immediately for next 30 days. Results will be evaluated by Executive Leadership Team (ELT) to determine frequency of video review at end of 30 days. TCI training refresher for all PRTF staff focusing on proper techniques using examples of restraints that were cited. To be completed by 2/8/19.</p> <p>Individual staff concerns.</p> <p>1. [The C/TCII]: upon notification of concerns about restraint, footage was reviewed by Program Manager and Senior Director of Compliance. Staff was suspended, retrained, and Employee Assistance Program referral made. Increased supervision of him on shift to begin on 1/9/19 by Program Manager, Director, Teaching Family Services (TFS) Manager, Lead Consultant and Chief Program Officer. Will suspend his training of staff in regard to TCI for next 90 days to focus on his professional retraining.</p> <p>2. [CYCW #1]: Performance correction (documented review of the restraint and feedback on how it was or was not in line with TCI) already completed and signed by employee based on review of restraint on 1/9/19. Retraining in TCI to be complete by 1/30/19.</p> <p>3. [CYCW #2]: performance correction (documented review of the restraint and feedback on how it was or was not in line with TCI) based on review of restraint to be complete by 1/9/19 and TCI retraining to be complete by 1/30/19."</p> <p>- Describe your plans to make sure the above happens.</p> <p>"2) Accountability Plans Documentation of retraining to be submitted to CPO, Human Resource, and Compliance for monitoring of completion within required</p>	V 537			

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NAME OF PROVIDER OR SUPPLIER  <b>BARIUM SPRINGS HOME FOR CHILDREN - KING HOI</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>138 BARIUM SPRINGS DRIVE STATESVILLE, NC 28677</b>		
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V 537	<p>Continued From page 21</p> <p>timeframes.</p> <p>All video reviews to be submitted to Director and CPO for review. Program Coordinator will track completion of video review and provide weekly summary of trends and patterns. Summary report to be reviewed by ELT every 30 days.</p> <p>Scheduled service delivery of Program Manager, Director, Clinical Director, TFS Manager, Lead Consultant and CPO will monitor for compliance with TCI techniques and restraint protocols."</p> <p>The facility was a locked PRTF (Psychiatric Residential Treatment Facility) which was serving 9 clients. The 3 impacted clients ranged in ages from 9 to 13 years-old and had various diagnoses including: Schizophrenia, in Partial Remission; Oppositional Defiant Disorder; Attention Deficit-Hyperactivity Disorder (ADHD), Dissociative Identity Disorder, Insomnia, Major Depressive Disorder, and Disruptive Mood Dysregulation Disorder. The 3 impacted clients had the following histories: 2 had suicidal thoughts, 3 had self-harmed, 3 had physical aggression, and 1 had been physically abused. On four different occasions, the use of force to either move and/or physically restrain these clients was implemented in a manner that was not consistent with TCI-approved techniques. One incident involved a client being "body slammed" by the C/TCII. A second incident involved CYCW #1 moving a client by dragging her by her arm down a hallway, which she reported had been approved by the C/TCII. A third incident involved CYCW #2 using his hands to push a client out of his room. A fourth incident involved CYCW #2 using his legs to push a client, who was on the ground, through a door way and then pulling the client by his arm. CYCW #1, CYCW #2 and the C/TCII's failure to demonstrate competence in the use of approved TCI</p>	V 537			

Division of Health Service Regulation

STATE FORM

6899

47UE11

If continuation sheet 22 of 25

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL049-119</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>01/14/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>BARIUM SPRINGS HOME FOR CHILDREN - KING HOI</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>138 BARIUM SPRINGS DRIVE STATESVILLE, NC 28677</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
V 537	Continued From page 22  interventions was detrimental to the health, safety and welfare of clients and constitutes a Type B rule violation. If the violation is not corrected within 45 days, an administrative penalty of \$200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 537			
V 736	27G .0303(c) Facility and Grounds Maintenance  10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.  This Rule is not met as evidenced by: Based on observation and interviews, the facility was not maintained in a safe and clean manner. The findings are:  Observation at approximately 10:10 am on 1/4/2019 revealed: - The weather was rainy; - There was a plastic container on the floor in front of a refrigerator in the kitchen; - Water was dripping from a vent in the ceiling into the container on the floor; - Water had splashed out of the container onto the floor.  Interview on 1/7/2019 with Child Youth Care Worker (CYCW) #1 revealed: - The leak in the kitchen had been present for at least the past two months; - The leak was only in the one area in front of the refrigerator;	V 736	27 G .303(c) Facility and Grounds Maintenance  Facilities has inspected the roof and still not able to locate the source of the leak. Primary problem is the roof pitch in that particular area. It is a 3/12 pitch which is the absolute minimum for shingles.  Facilities will enter the attic to intercept leak and place a catch container to keep the leak from entering the kitchen. This will be checked after each rain storm and replaced until problem is fully resolved.  Facilities will be extending the sealing further up the roof including the adjacent valley.	1/30/2019  1/30/2019  2/28/2019	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL049-119</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>01/14/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>BARIUM SPRINGS HOME FOR CHILDREN - KING HOI</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>138 BARIUM SPRINGS DRIVE STATESVILLE, NC 28677</b>		
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V 736	<p>Continued From page 23</p> <ul style="list-style-type: none"> <li>- Water from the leak had not contaminated the food.</li> </ul> <p>Interview on 1/7/2019 with CYCW #2 revealed:</p> <ul style="list-style-type: none"> <li>- The leak in the kitchen occurred every time it rained;</li> <li>- Water from the leak had not contaminated the food;</li> <li>- The Maintenance Department had attempted to fix the leak.</li> </ul> <p>Interview on 1/7/2019 with CYCW #3 revealed:</p> <ul style="list-style-type: none"> <li>- The leak in the kitchen had occurred whenever it rained;</li> <li>- The amount of water from the leak did not usually completely fill up the container placed beneath it to catch the rain;</li> <li>- Water from the leak had not contaminated the food;</li> <li>- Clients were not allowed in the kitchen.</li> </ul> <p>Interview on 1/9/2019 with the Building Maintenance Supervisor (BMS) revealed:</p> <ul style="list-style-type: none"> <li>- The leak in the kitchen had been present for as long as the BMS had worked for the facility, which was approximately 2 years;</li> <li>- The roofing materials were ten years old;</li> <li>- The Maintenance Department had been actively trying to fix the leak;</li> <li>- Attempts to patch the leak had been made multiple times;</li> <li>- Inspections of the roof did not result in locating the origin of the leak;</li> <li>- The roof valley and ridge had been sealed to try to stop the leak;</li> <li>- The roof could go for months without leaking, and then start again;</li> <li>- Although no mold had been found in the facility's attic or ventilation system near the leak, a mold treatment/inhibiting product had been applied to</li> </ul>	V 736		



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL049-119</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>01/14/2019</b>
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V 736	Continued From page 24  prevent mold from developing; - The leak had not contaminated any food supplies; - The BMS would continue to try to locate and repair the leak in the kitchen.	V 736		



NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**

ROY COOPER • Governor

MANDY COHEN, MD, MPH • Secretary

MARK PAYNE • Director, Division of Health Service Regulation

January 18, 2019

Kristin Uhler-Comte, Licensing Specialist  
Barium Springs Home for Children  
PO Box 1  
Barium Springs, NC 28010-0001

**RECEIVED**

**JAN 24 2019**

**DHSR-MH Licensure Sect**

Re: Annual & Complaint Survey Completed January 14, 2019  
Barium Springs Home for Children-King Home, 138 Barium Springs Drive,  
Statesville, NC 28677-6238  
MHL# 049-119  
E-mail Address: kmuhler@childrenshopealliance.org  
Intake #: NC146357, NC146866, NC146974 & NC147124

Dear Ms. Uhler-Comte:

Thank you for the cooperation and courtesy extended during the annual and complaint survey completed January 14, 2019. Three of the complaints were unsubstantiated (NC146357, NC146866 & NC146974), and one was substantiated (NC147124).

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

**Type of Deficiencies Found**

- Type B rule violation is cited for 10A NCAC 27E .0108 Training in Seclusion, Physical Restraint and Isolation Time-Out (V537).
- The other tag cited is a standard level deficiency.

**Time Frames for Compliance**

- Type B violation must be **corrected** within 45 days from the exit date of the survey, which is February 28, 2019. Pursuant to North Carolina General Statute § 122C-24.1, failure to correct the enclosed deficiency by the 45<sup>th</sup> day from the date of the survey may result in the assessment of an administrative penalty of \$200.00 (Two Hundred) against Barium Springs Home for Children for each day the deficiency remains out of compliance.
- Standard level deficiency must be **corrected** within 60 days from the exit of the survey, which is March 15, 2019.

**What to include in the Plan of Correction**

- Indicate what measures will be put in place to **correct** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to **prevent** the problem from occurring again.
- Indicate **who will monitor** the situation to ensure it will not occur again.

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603  
MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718  
www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

January 18, 2019  
Kristin Uhler-Comte  
Barium Springs Home for Children

- Indicate **how often** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records.  
**Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.**

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

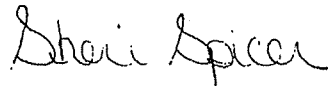
Mental Health Licensure and Certification Section  
NC Division of Health Service Regulation  
2718 Mail Service Center  
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Barbara Perdue at (336) 861-6283.

Sincerely,



Clarice Rising, MSW, LCSW  
Facility Compliance Consultant I



Sheri Spicer  
Facility Compliance Consultant I



Angela Medlin  
Facility Compliance Consultant I  
Mental Health Licensure & Certification Section

Cc: Rob Robinson, Director, Alliance Behavioral Health LME/MCO  
Wes Knepper, Quality Management Director, Alliance Behavioral Health LME/MCO  
Trey Suttan, Director, Cardinal Innovations LME/MCO  
Onika Wilson, Quality Management Director, Cardinal Innovations LME/MCO  
Leza Wainwright, Director, Trillium Health Resources LME/MCO  
Fonda Gonzales, Interim Quality Management Director, Trillium Health Resources LME/MCO  
Sarah Stroud, Director, Eastpointe LME/MCO  
Jeanette Jordan-Huffam, Quality Management Director, Eastpointe LME/MCO  
W. Rhett Melton, Director, Partners Behavioral Healthcare LME/MCO  
Selenna Moss, Quality Management Director, Partners Behavioral Healthcare LME/MCO  
Victoria Whitt, Director, Sandhills Center LME/MCO  
Mary Kidd, Quality Management Director, Sandhills Center LME/MCO  
Brian Ingraham, Director, Vaya Health LME/MCO  
Patty Wilson, Quality Management Director, Vaya Health LME/MCO  
File