

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL063-100	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/15/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER JACKSON SPRINGS TREATMENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 778 HOFFMAN ROAD WEST END, NC 27376
---	---

(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	<p>INITIAL COMMENTS</p> <p>An annual and complaint survey was completed on March 15, 2019. The complaint was substantiated (Intake #NC00147385). Deficiencies were cited.</p> <p>This facility is licensed for the following services category: 10A NCAC 27G 1900 Psychiatric Residential Treatment for Children and Adolescents.</p>	V 000		
V 110	<p>27G .0204 Training/Supervision Paraprofessionals</p> <p>10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS</p> <p>(a) There shall be no privileging requirements for paraprofessionals.</p> <p>(b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter.</p> <p>(c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served.</p> <p>(d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence.</p> <p>(e) Competence shall be demonstrated by exhibiting core skills including:</p> <ol style="list-style-type: none"> (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. <p>(f) The governing body for each facility shall develop and implement policies and procedures</p>	V 110		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL063-100	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/15/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER JACKSON SPRINGS TREATMENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 778 HOFFMAN ROAD WEST END, NC 27376
---	---

(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 110	<p>Continued From page 1</p> <p>for the initiation of the individualized supervision plan upon hiring each paraprofessional.</p> <p>This Rule is not met as evidenced by: Based on record reviews, interviews and observations, the facility management failed to assure 2 of 6 (#2 and #6) audited current paraprofessional staff and 1 of 1 Former Staff (FS #7) demonstrated competence. The findings are:</p> <p>During the survey on 3/7/19, at approximately 1:08 PM, a female staff in another area of the facility was overheard speaking to another staff person on her interaction with a client: - "I told him (client) - He don't like you, lot of people don't like you! Grown people don't like you!" - The female staff further said in a loud, angry voice - "They don't have 7 people today. If they had 7 people I probably could go!"</p> <p>During interviews on 3/6/19, clients reported the following: - Staff say "inappropriate" things and then say they are just joking. - A client reported a former staff threatened to "kill" him - "Staff are always playing around with us in the self reflection room. You might be sitting down, perfectly quiet. Staff #2 will push you against the wall then says 'You trying to hit me?' Then he restrains you."</p> <p>During interviews with clients on 3/7/19, a client reported:</p>	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL063-100	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/15/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER JACKSON SPRINGS TREATMENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 778 HOFFMAN ROAD WEST END, NC 27376
---	---

(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 110	<p>Continued From page 2</p> <ul style="list-style-type: none"> - He did not trust Staff #6. - Staff #6 said he was "annoying." "She said nobody likes me." - He said the "putdowns" from Staff #6 hurt his feelings and he was upset. <p>Review on 3/4/19 of staff documentation of client behavioral incidents revealed the following incident:</p> <ul style="list-style-type: none"> - On 3/4/19, Client #1 ran outside of the building and climbed on the roof. He walked around on the roof picking shingle particles off the roof and throwing them. The client threatened to jump. Staff were unable to deescalate him and called police. - Staff did not document any additional action steps/interventions or strategies were implemented with Client #1. <p>Review on 3/15/19 of the police report on response to the call for service from facility staff on 3/34/19 revealed:</p> <ul style="list-style-type: none"> - Incident involved - "Crime/Incident - Destruction/Damage/Vandalism of Property" at 12:46 PM to a door in the facility. - Client #1 was on the roof of the facility. - A detective talked Client #1 into coming off the roof of the facility. - Client #1 informed the officer "he was upset that staff had not let him outside to play with everyone so he kicked open the building door." - Once outside, Client #1 climbed on the roof and began yelling at staff. - When asked, Client #1 informed the Officer he climbed on the roof in order to hurt himself. - Former Staff #1 reported the client was "waving a stick around with a nail sticking through it" while he was standing on the roof. - Officer reported he made FS #7 that Client #1 admitted he wanted to hurt himself by jumping off 	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL063-100	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/15/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER JACKSON SPRINGS TREATMENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 778 HOFFMAN ROAD WEST END, NC 27376
---	---

(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 110	<p>Continued From page 3</p> <p>the roof and she informed the officer, she would notify the facility nurse.</p> <ul style="list-style-type: none"> - The officer reported the case was "Closed/Cleared." <p>During interview on 3/6/19 Client #1 reported:</p> <ul style="list-style-type: none"> - He does not trust staff. - He ran away from the facility last month (February) when the staff on duty was asleep. He said there was only one staff on duty at night until after he ran away. - Staff are not fair with the points and levels in the behavior system. All the residents were punished and could not watch movies because he "misused" the facility's 'Fire Stick' which allowed them access to movies. He said this was not fair to the others. - The following occurred on 3/4/19: <ol style="list-style-type: none"> 1. Staff would not let him go outside to play basketball with the other clients. 2. He broke through the door leading to the outside of the facility and climbed on the roof. 3. He was hurt and angry and felt like killing himself. 4. Staff did not try to help him however, threatened him with more consequences if he did not come down. 5. He came down when the police came and talked to him about what was going. He felt like they wanted to help him. 	V 110		
V 367	<p>27G .0604 Incident Reporting Requirements</p> <p>10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</p> <p>(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</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL063-100	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/15/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER JACKSON SPRINGS TREATMENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 778 HOFFMAN ROAD WEST END, NC 27376
---	---

(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 367	<p>Continued From page 4</p> <p>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:</p> <p>(1) reporting provider contact and identification information;</p> <p>(2) client identification information;</p> <p>(3) type of incident;</p> <p>(4) description of incident;</p> <p>(5) status of the effort to determine the cause of the incident; and</p> <p>(6) other individuals or authorities notified or responding.</p> <p>(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:</p> <p>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or</p> <p>(2) the provider obtains information required on the incident form that was previously unavailable.</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL063-100	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/15/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER JACKSON SPRINGS TREATMENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 778 HOFFMAN ROAD WEST END, NC 27376
---	---

(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 367	<p>Continued From page 5</p> <p>(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).</p> <p>(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 by the Secretary via electronic means and shall include summary information as follows:</p> <ol style="list-style-type: none"> (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. <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the</p>	V 367		
-------	---	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL063-100	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/15/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER JACKSON SPRINGS TREATMENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 778 HOFFMAN ROAD WEST END, NC 27376
---	---

(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 367	<p>Continued From page 6</p> <p>facility management failed to report all Level II incidents to the LME within 72 hours of becoming aware of the incident as required. The findings are:</p> <p>Review on 3/7/19 of Client #1's record revealed:</p> <ul style="list-style-type: none"> - Age 17 - Admission date of 9/6/2018 - Diagnoses of Disruptive Mood Dysregulation Disorder; Conduct Disorder, Childhood Onset Type; Attention Deficit Hyperactivity Disorder (ADHD) Combined Presentation - per History; Post Traumatic Stress Disorder; Child Neglect; Child Physical Abuse; Child Psychological Abuse <p>Review on 3/4/19 of Client #2's record revealed:</p> <ul style="list-style-type: none"> - Age 13 - Admission date of 10/27/18 - Diagnoses of Unspecified Bipolar and Related Disorder; Conduct Disorder, Childhood Onset Type; ADHD, Combined Presentation; Posttraumatic Stress Disorder; Child Sexual Abuse - Victim <p>Review on 3/4/19 of Client #3's record revealed:</p> <ul style="list-style-type: none"> - Age 14 - Admission date of 9/21/18 - Diagnoses of Conduct Disorder, Childhood Onset Type; Disruptive Mood Dysregulation Disorder; ADHD, Combined Presentation - per History; Cannabis Use Disorder, Moderate <p>Review on 3/7/19 of Client #5's record revealed:</p> <ul style="list-style-type: none"> - Age 14 - Admission date of 7/20/18 - Diagnoses of Disruptive Mood Dysregulation Disorder; Conduct Disorder, Childhood Onset; ADHD, Combined Presentation <p>Review on 3/15/19 of the facility's policy on</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL063-100	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/15/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER JACKSON SPRINGS TREATMENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 778 HOFFMAN ROAD WEST END, NC 27376
---	---

(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 367	<p>Continued From page 7</p> <p>incident reporting revealed staff are directed to report the following incidents as Level II incidents to the state in the format required by the state:</p> <ul style="list-style-type: none"> - emergency, unplanned use of a restrictive intervention or any planned use that: a) exceeds authorized limits; b) results in discomfort or complaint - any suicide attempt - any aggressive or destructive act that involves: a) report to law enforcement; b) potentially serious threat to the health or safety of self or others - any consumer absence that requires police contact <p>Review on 3/4/19 of staff documentation of client behavioral incidents for the six months from November 2018 through March 2019 revealed the following examples of incidents that were not reported as required:</p> <ol style="list-style-type: none"> 1. 11/15/18 - Client #6 tried to injure himself. He kicked the wall and said "I don't want to be here." Staff #4 held the client in a "one-man therapeutic hold" for 35 minutes. 2. 11/26/18 - Police were called when staff attempted to break up a fight between Client #3 and a peer and Client #3 attempted to elope from the facility. Staff involved not identified. 3. 12/11/18 - Staff used a two man therapeutic restraint on Client #3 for 15 minutes to prevent him from fighting a peer. Client #3 sustained a black eye during the fight with his peer. Staff involved not identified. 4. 1/30/19 - "Child therapeutic hold" for 10 minutes on Client #5. Client hit his head on the wall, spit and kicked at staff during restraint. Staff involved not identified. 5. 7. 2/8/19 - Staff #2 and a female staff (unable to identify) placed Client #5 in a "Child therapeutic hold" for 15 minutes. Client hit his head on the 	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL063-100	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/15/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER JACKSON SPRINGS TREATMENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 778 HOFFMAN ROAD WEST END, NC 27376
---	---

(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 367	<p>Continued From page 8</p> <p>wall, spit and kicked at staff during restraint.</p> <p>6. 2/9/19 - Client #5 hit his head on the wall, spit and kick staff. Staff #1 and Staff #2 placed client in a 2-man hold for 15 minutes.</p> <p>7. 2/9/19 - Client #2 "got a nail from his room and tried to give it to a peer." The client also tried to climb the fence in the yard and attempted to exit the front hall door. Staff #1 and Staff #2 held the client against the wall in a restraint for 8 minutes.</p> <p>8. 2/14/19 - Client #5 was involved in a fight with Client #2 outside in the recreation area. Staff placed Client #5 in a physical restraint for 15 minutes. Client #5 was escorted to his room, spit, scratched staff and banged his head on the wall during the restraint. Police were called. Staff not identified.</p> <p>9. 2/15/19 - Staff #2 and a female staff (unable to identify) placed Client #5 in a "high level hold" for 15 minutes. The client received "superficial scratches" during the restraint which were treated by the nurse.</p> <p>10. 2/27/19 - Client #2 said "I want to die." He attempted to choke himself with his jogging pants. Staff (not identified) intervened and placed him on 24 hour suicide watch. Staff not identified.</p> <p>11. 3/1/19 - Client #2 threatened and attempted suicide with his clothing. Staff intervened and placed him on 24 hour suicide watch. Staff not identified.</p> <p>12. 3/4/19 - Client #1 ran outside of the building and climbed on the roof. He walked around on the roof picking shingle particles off the roof and throwing them. The client threatened to jump. Staff were unable to deescalate him and called police.</p> <p>Review on 3/15/19 of a report from local police revealed from January 2019 through March 2019 police documented involvement in 9 (nine) incidents at the facility in response to staff calls</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL063-100	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/15/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER JACKSON SPRINGS TREATMENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 778 HOFFMAN ROAD WEST END, NC 27376
---	---

(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 367	<p>Continued From page 9</p> <p>for assistance.</p> <ol style="list-style-type: none"> 1. 2/4/19 - Missing person 2. 2/11/19 - Call for service/Handled on scene 3. 2/14/19 - Fight 4. 2/15/19 - Warrant 5. 2/19/19 - Disturbance/Handled on scene 6. 3/4/19 - Disturbance 7. 3/12/19 - Suicide/Handled on scene 8. 3/13/19 - Fight/Handled on scene 9. 3/14/19 - Assault <p>- No specific clients were identified in the police document.</p> <p>Additionally, review on 3/15/19 of the above documents revealed:</p> <ul style="list-style-type: none"> - No Level II incident reports were found documenting the above identified client behavioral incidents in the facility. Only two Level II incidents were documented on the state reporting system for the November 2018 through then end of the survey period. - No Level II incident reports were found documenting the above incidents which required police involvement at the facility. <p>During interview on 3/7/19, the Senior Team Leader said:</p> <ul style="list-style-type: none"> - He is responsible for assuring staff complete behavior reports on incidents of client behaviors. - He reviews all reports of staff use of a physical restraint on a client. - Reports are submitted to the management office for review and submission to the State as required. - He was unable to confirm if the above reports were submitted as required. <p>During interview on 3/7/19, the management representative (Director of Admissions/Referrals:) - was unable to confirm management completed</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL063-100	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/15/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER JACKSON SPRINGS TREATMENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 778 HOFFMAN ROAD WEST END, NC 27376
---	---

(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 367	Continued From page 10 the required submission of the above Level II incidents of client physical restraints and police intervention. - reported all incidents were reviewed and determined if Level II reports then subsequently completed by the agency's Vice President of Administration. - said she would refer the information to her.	V 367		
V 513	27E .0101 Client Rights - Least Restrictive Alternative 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports that promote a safe and respectful environment. These include: (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include: (1) using the intervention as a last resort; and (2) employing the intervention by people trained in its use.	V 513		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL063-100	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/15/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER JACKSON SPRINGS TREATMENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 778 HOFFMAN ROAD WEST END, NC 27376
---	---

(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 513	<p>Continued From page 11</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility management failed to assure staff (#1/Senior Team Leader & #2): 1) used the least restrictive and most appropriate methods and settings and; 2) employed approved restrictive intervention techniques when restraining clients. The findings are:</p> <p>Review on 3/7/19 of Staff #1/Senior Team Leader's record revealed: Hire date of 6/11/17 as Residential Mentor. Current position as Senior Team Leader. Documentation of training in alternatives to restrictive interventions and physical restraint as refresher on 5/25/18.</p> <p>Review on 3/7/19 of Staff #2's record revealed: Hire date of 6/13/14 as Residential Mentor. Current position as Team Leader. No documentation of current training in restrictive interventions and physical restraint found.</p> <p>Review on 3/7/19 of Client #1's record revealed: - Age 17 - Admission date of 9/6/2018 - Diagnoses of Disruptive Mood Dysregulation Disorder; Conduct Disorder, Childhood Onset Type; Attention Deficit Hyperactivity Disorder (ADHD) Combined Presentation - per History; Post Traumatic Stress Disorder; Child Neglect; Child Physical Abuse; Child Psychological Abuse</p> <p>Review on 3/4/19 of Client #2's record revealed: - Age 13 - Admission date of 10/27/18 - Diagnoses of Unspecified Bipolar and Related Disorder; Conduct Disorder, Childhood Onset Type; ADHD, Combined Presentation; Posttraumatic Stress Disorder; Child Sexual</p>	V 513		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL063-100	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/15/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER JACKSON SPRINGS TREATMENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 778 HOFFMAN ROAD WEST END, NC 27376
---	---

(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 513	<p>Continued From page 12</p> <p>Abuse - Victim</p> <p>Review on 3/7/19 of Client #6's record revealed:</p> <ul style="list-style-type: none"> - Age 13 - Admission date 10/15/18 - Diagnoses of ADHD, Combined Presentation; Disruptive Mood Dysregulation Disorder; Conduct Disorder, Childhood Onset Type <p>Interview on 2/28/19 with the Senior First Responder revealed:</p> <ul style="list-style-type: none"> - He provides staff training in restrictive interventions. - Staff are trained in Crisis Prevention Intervention (CPI) and receive an update each year. <p>Review on 3/4/19 of staff documentation of client behavioral incidents for a 6 month period from November 2018 through March 2019 revealed staff used restrictive interventions/procedures that were not a part of approved restrictive intervention methods. The following are examples:</p> <ul style="list-style-type: none"> - 11/15/18 - Client #6 tried to injure himself. He kicked the wall and said "I don't want to be here." Staff #4 held the client in a "one-man therapeutic hold" for 35 minutes. - 2/9/19 - Client #2 "got a nail from his room and tried to give it to a peer." Staff reported the client also tried to climb the fence in the yard and attempted to exit the front hall door. Staff #1 and Staff #2 restrained the client by holding him against the wall for 8 minutes. <p>During interview on 3/6/19, Client #1 reported:</p> <ul style="list-style-type: none"> - He has witnessed other clients being restrained and screaming "My arm! My leg!" - He was restrained against the wall with his arms stretched out. He said "Staff took me outside and 	V 513		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL063-100	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/15/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER JACKSON SPRINGS TREATMENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 778 HOFFMAN ROAD WEST END, NC 27376
---	---

(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 513	<p>Continued From page 13</p> <p>pressed me up against the brick wall because there are no cameras. They pulled my arms behind my back and punched me.</p> <p>Interview on 3/6/19 with a client revealed:</p> <ul style="list-style-type: none"> - He has been in the facility for approximately 5 months. - Staff #2 restrained him by holding him against the wall for approximately 15 minutes. - He does not feel safe in the unit he lives on in the facility. He is younger and smaller than the other residents. <p>Interview on 3/6/19 with another client revealed:</p> <ul style="list-style-type: none"> - He has been in the facility for approximately 5 months and thinks he will be leaving soon. - He has never been restrained by staff, however, he has witnessed staff restrain other clients by holding them with their face "on the wall." <p>Interview on 3/6/19 with a third client revealed:</p> <ul style="list-style-type: none"> - He has been in the facility for 10 months. - He has not been restrained on the wall. However, Staff #1/Senior Team Leader and a staff who is no longer working at the facility restrained him on two occasions for inappropriate/unacceptable "verbal" behavior. - The client said "They shouldn't restrain you when you're just verbal. It adds fuel to the fire." <p>Interview on 3/6/19 with another client revealed:</p> <ul style="list-style-type: none"> - He has been in the facility for 5 months. - Staff say they have to restrain clients when "we get out of hand." - His arms hurt when they restrain him by stretching his arms out and pulling them back. Staff do not stop pulling his arms back when he tells them he is in pain. - He said "They could talk to us more. They could allow us to talk to our mom when we're upset. It 	V 513		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL063-100	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/15/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER JACKSON SPRINGS TREATMENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 778 HOFFMAN ROAD WEST END, NC 27376
---	---

(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 513	<p>Continued From page 14</p> <p>hurts my feelings when they just restrain me cause I'm upset."</p> <p>Interview on 3/6/19 with a fifth client revealed:</p> <ul style="list-style-type: none"> - He has not had any problems with staff in the facility. He said "Staff treat me ok." - He tries to go into the "self-reflection" room when he becomes angry. - He has been restrained "on the wall" with his arms out to the side. <p>Interview on 3/7/19 with a staff working second shift revealed:</p> <ul style="list-style-type: none"> - He has seen staff restrain a client using techniques that were not a part of their training and could cause pain or injury. - He witnessed staff restraining a client who had a cast on his arm. He said "They never should have restrained that kid." - He reported the staff who implemented the restraint no longer work at the facility. <p>Interview on 3/7/19 with the Staff #1/Senior Team Leader revealed:</p> <ul style="list-style-type: none"> - Staff do not restrain a client for verbal outburst. The client must be aggressive towards himself or others. - Staff are permitted to restrain a client in a physical hold which places him facing the wall. - Staff place a pillow between the client's head and the wall to prevent the client from banging his head against the wall. 	V 513		