Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL081-110	A. BUILDING: ______ B. WING ______	R 04/18/2019

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DIRECTCARE GROUP HOME	106 ORCHARD STREET FOREST CITY, NC 28043

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V 000	INITIAL COMMENTS A limited follow up survey for the Type A1 was completed on April 18, 2019. This was a limited follow up survey, only 10A NCAC 27G .1701 Scope- Residential Treatment Staff Secure for Children and Adolescents (V293) with the cross-reference citations of 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109), 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110), 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plans (V112), and 10A NCAC 27E .0101 Client Rights-Least Restrictive Alternative (V513) were reviewed for compliance. 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 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness;	V 109		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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V 109	Continued From page 1 (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 3 of 3 audited Qualified Professionals (Licensee/QP #1, House Manager (HM)/QP #2, QP #3 and QP #4) demonstrated the knowledge, skills and abilities required by the population served. The findings are: Review on 4/18/19 of the Licensee/QP #1's personnel record revealed: -Hire date: 1/20/15 -Education: Bachelor of Science (BS) degree in Geography -Work experience in the mental health field for at least 15 years. Review on 4/18/19 of the HM/QP #2's personnel	V 109		

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record revealed:
-Hire date: 11/29/16
-Education: Bachelor of Social Work (BSW) degree
-Work experience in the mental health field for at least 8 years.

Review on 4/18/19 of QP #3's personnel record revealed:
-Hire date: 1/26/19
-Education: BS degree in Social Studies
-1/26/19, a written and signed QP job description of responsibilities that included:
-Coordination, oversight and supervision of activities and personnel involved in providing residential care services to individuals;
-Problem-solving duties that involved "studying the situation, developing possible solutions, deciding on most appropriate plan for solution, and implementing approved plan of action;"
-Training and managing paraprofessional staff;
-Monitoring clients in residential care.

Review on 4/8/19 of Former Client (FC #3)'s record revealed:
-He was 14 years old, readmitted on 1/30/19, and discharged on 3/29/19;
-His diagnoses were Oppositional Defiant Disorder (ODD), Attention-Deficit Hyperactivity Disorder;
-A history of self-harming (cutting) behaviors and hospitalizations for mental health stabilization;
-His treatment plan was updated on 2/4/19 and 3/18/19 and included:
-a safety plan which had staff to:
-become educated about and identify FC #3's warning signs of an impending aggressive or frustrated episode and to know what precautions to take to ensure FC #3's safety;
-"immediately" contact 911 emergency service

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if he displayed aggressive or destructive behaviors;
-assess and observe the area where FC #3 was present for any object(s) that could be used by him to self-harm and/or harm others;
-a behavioral plan for staff to remove objects from FC #3's environment(s) that could be used by him as a weapon;
-a crisis plan for FC #3 to:
-be encouraged to express his feelings and thoughts when he was argumentative, aggressive or impulsive in his behaviors;
-be monitored to ensure he was safe and away from any objects that could be used by him to self-harm or harm others;
-a 2/4/19 self-harm goal that was added and directed staff to:
-follow FC #3's safety and crisis plans which included the use of restrictive interventions if and when he became a danger to himself and/or others;
-conduct checks of his bedroom for objects FC #3 could have used to self-harm and/or harm others;
-a 3/18/19 written request for PRTF admission to assist FC #3 with his mental health and behaviors due to continued self-harming and elopement incidents.

Review on 4/8/19 of 4 of 4 written incident reports for FC #3 in the North Carolina Incident Response Improvement System (IRIS) from 2/24/19-3/16/19 revealed:
-The reports were submitted into IRIS by the HM/QP #2 and authorized by the Licensee/QP #1;
-All of the reports had incident prevention statements that FC #3 needed a higher level of care;
-There was 1 statement out of the 4 of the reports

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that had one preventive strategy used by a staff;
-The first 2 incident reports had occurrences on 2/4/19 and 3/9/19 at "unknown times" with FC #3 having found objects he used to cut himself;
-On 2/4/19, FC #3 and his 2 housemates were accompanied and supervised by 2 staff (QP #3 and Staff #2) to a local park where he was observed by staff picking up objects from the ground and placing the objects in his pocket;
-One of the objects was identified by a staff as a piece of glass that FC #3 removed from his pocket while back at the facility and began to cut himself with the glass;
-The cause of this incident was stated as "client's behaviors;"
-There was an additional incident prevention statement that had, "Going forward staff will not take clients with these behaviors to the park;"
-On 3/9/19, FC #3 went into his bedroom, closed his door with a staff (Staff #2) who went "immediately" into his room and found him seated on the floor with his left arm bleeding;
-Staff #2 applied pressure to his wound to stop the bleeding and called 911 emergency service;
-The object FC #3 used to harm himself was not identified and FC #3 told staff he had already disposed of the object;
-A statement in the report about the cause of the incident was that FC #3 was not upset;
-FC #3 was taken to a local hospital by local emergency medical service (EMS) for medical and psychiatric evaluations;
-The 3rd and 4th incident reports had occurrences on 3/10/19 at 8:40 pm and 3/16/19 at 8:47 pm with FC #3 having eloped from the facility while being observed each time by a staff (HM/QP #2 on 3/10/19 and Staff #2 on 3/16/19);
-The statements were that FC #3 had climbed out his bedroom window and was seen walking

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up the road with Client #2;
-Additional statements had FC #3 being verbally prompted by staff to return to the facility before the Licensee/QP #1, local law enforcement and the legal guardian were notified of the elopement incidents;
-Both these clients were returned to the facility by law enforcement within 20-25 minutes of being away from the facility;
-The cause of the incidents was FC #3 and Client #2 wanted to smoke and had intentions to return to the facility;
-On 3/16/19 and after FC #3 was returned to the facility by law enforcement, he went into the backyard, threw a rock and broke a glass window to a barn;
-As a result of the broken glass window, he was charged with property damage.

Review on 4/8/19 of written Child and Family Team (CFT) meeting notes dated 2/4/19 and 3/6/19 for FC #3 revealed:
-The participants in his treatment team included FC #3, his legal guardian, a Local Management Entity (LME) Care Coordinator, a representative from a county department of social services (DSS), FC #3's juvenile probation officer (PO) and the Licensee/QP #1;
-The 2/4/19 meeting had FC #3's new self-harm goal and strategies that included having staff check his room for objects that could be used to self-harm and for staff to follow his safety and crisis plans;
-The 3/6/19 meeting note indicated FC #3's self-harm goal was reviewed by the team and a higher level of care for FC #3 continued to be sought by the team due to his continued self-harming behaviors;
-There were no additional statements or documented notes for review and that indicated

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the team's discussion about what treatment strategies were used with FC #3 by staff and the level of their effectiveness with his behaviors.

Further review on 4/8/19 of FC #3's record revealed:
-Printed progress notes that were written by staff and ranged in dates from 2/24/19 to 3/16/19;
-2/24/19, Staff #2 observed "surgical marks" on FC #3's left arm while outside and he was brought indoors and had First Aid applied by Staff #2;
 -FC #3 went to his bedroom, Staff #2 checked on him and found he had cut himself on glass that he said he picked up earlier at the park;
 -FC #3 refused to turn over the glass to Staff #2 which led her to call local law enforcement;
 -FC #3 was transported to a local hospital by local law enforcement for a psychiatric evaluation;
-There were no written notes from QP #3 about FC #3 and dated 2/24/19 that were made available for review;
-3/9/19 at approximately 5:12 pm, Staff #2 observed FC #3 enter his bedroom close his door;
 -She went into his room and found him seated on the floor with cut marks and bleeding on his left arm;
 -She applied pressure to his wound to control the bleeding and called 911;
 -FC #3 told Staff #2 he had already disposed of the object he used to cut himself;
 -Local EMS and local law enforcement arrived and FC #3 was transported to a local hospital;
-3/10/19 at approximately 8:32 pm, the HM/QP #2 stated FC #3 had eloped through his bedroom window, was returned to the facility by local law enforcement and he was back in bed by 9:30 pm;
 -FC #3 stated he went to a parking lot at a local grocery store to smoke and he intended to return

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V 109	Continued From page 7 to the facility; -3/16/19 at approximately 8:45 pm, Staff #4 stated FC #3 had eloped through his bedroom window, which was his 2nd elopement, and was returned by local law enforcement; -FC #3 was away from the facility between 20-25 minutes for each of these 2 elopement incidents. Interview on 4/8/19 with the HM/QP #2 revealed: -She had been a House Manager over 2 years; -Her continuing job duties included supervising the paraprofessional staff and providing their monthly clinical supervision contacts, reviewing staff notes at least weekly, making sure clients were transported to and kept their scheduled appointments, ensuring the facility had staff coverage of all shifts and filling in as a direct care staff when needed; -She reviewed and used written staff notes when she completed Levels II and III IRIS reports on client incidents; -Staff directly involved in a client incident were responsible for completing their written notes which were usually found in the daily client notes on each shift; -She did not update the client treatment plans as this responsibility was assigned to QP #4 by the Licensee/QP #1; -She did not usually attend client CFT meetings unless asked to attend the meetings by the Licensee/QP #1; -She was informed by the Licensee/QP #1 of any client changes or treatment recommendations that came from the client CFT meetings; -FC #3 was readmitted the end of 1/2019 and had weekly individual therapy provided by a local outpatient mental health provider; -She made sure he was transported to his individual therapy appointments after school; -She had not talked directly with FC #3's	V 109		

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V 109	Continued From page 8 individual therapy provider about treatment recommendations as this communication would have occurred between the therapist and with the Licensee/QP #1; -A part of FC # 3's safety plan was for him to keep his bedroom door opened when in his room; -She was not certain where this safety measure originated but this measure was communicated to her by the Licensee/QP #1 and she and the Licensee/QP #1 communicated the information to staff; -FC #3 had 2 incidents of self-harming behavior (cutting), which occurred on 2/24/19 and 3/9/19, and 2 incidents of elopement, which occurred on 3/10/19 and 3/16/19 ; -She did not know the details of FC #3's incident on 2/24/19 in which he cut himself with a piece of glass because she was not at the facility when the incident occurred; -She did not recall having a conversation with QP #3 or Staff #2 about FC #3 having picked up glass at the park and placing it in his pocket and she was not aware of the other objects he had in his pocket; -Her written IRIS report was based on Staff #2's notes and the Licensee/QP #1 added information he knew about to the reports; -She did not know if FC #3 actually cut himself on 3/9/19 and stated the Licensee/QP #1 and Staff #2 would have the details of this incident; -If she had asked or was told by Staff #2 about the object FC #3 had on 3/9/19 that he may have used to cut himself and disposed of, she did not remember the conversation; -FC #3 fractured a finger from playing basketball during his prior PRTF admission and he was readmitted with a plastic splint around his finger to straighten his finger; -He was seen by a local bone specialist at the end of 2/2019 or first of 3/2019 to have his finger	V 109		

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V 109	Continued From page 9 splint replaced with a smaller splint and had a metal piece instead of a plastic piece on his replaced splint; -FC #3 might have used the metal piece on his splint to cut himself on 3/9/19 but she did not know what object he tried using on himself; -There were no special instructions or extra precautions taken with FC #3 having a metal piece on his finger splint; -She worked as staff on 3/10/19 when FC #3 had the 1st elopement; -FC #3 went to his bedroom after he watched a movie and closed his bedroom door; -She told him he had to keep his door opened because it was part of his safety plan; -He became mad that his door had to be kept opened because he did not want the hallway light shining into his room while trying to sleep; -She stated, "I let him shut his door;" -She went into FC #3's room about 5 minutes later and used a flashlight on her phone to check on him; -She found he had stuffed his bed with clothes and books to make it appear he was in bed; -The window in his bedroom was opened and he had climbed out of his window; -She checked Client #2's room and found he was not there and his bedroom window was opened; -She notified Licensee/QP #1, local law enforcement and both of the clients' parents of their elopement; -Both clients were returned to the facility about 20 minutes later by law enforcement; -FC #3's consequence for his elopement behavior included loss of a level (a behavioral reward system established in the facility) which meant he had an earlier bed time and a loss of telephone privileges that he had to earn back with appropriate behaviors;	V 109		

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V 109	Continued From page 10 -She did not know if FC #3's treatment plan had been updated to include the strategy of his keeping his bedroom door opened. Interview on 4/15/19 with HM/QP #2 revealed: -She believed FC #3 may have missed 2-3 of his therapy appointments because he was hospitalized due to continued self-harming behaviors; -She initially could not provide the dates of his appointments without calling the local outpatient mental health provider because she had thrown away her 2/2019 and 3/2019 calendars; -She later provided the dates of his 12 scheduled individual therapy appointments that ranged in dates from 2/1/19 to 3/21/19; -She did not know the reason(s) FC #3 had 2 scheduled individual therapy appointments on 2/1/19 and 3/11/19; -QP #4 had incorrectly documented the dates and numbers of FC #3's behaviors in his treatment plan as FC #3 had no aggressive or self-harming behaviors on 2/14/19 and 2/21/19. Interview on 4/10/19 with QP #3 revealed: -She worked as staff on Wednesdays and Thursdays from 4:00 pm to 12:00 midnight and worked a day shift every other Sunday; -She was permitted to supervise paraprofessional staff when she worked at the facility; -She worked with the clients to support them with their goals which included her listening when a client needed to talk and she tried to help them make better decisions; -Clients #1, #2 and FC #3 went on outings during the day shift on Sundays and they were always accompanied by 2 staff to monitor them for safety; -2/24/19, Clients #1, #2 and FC #3 were taken to a local park by her and Staff #2 on the facility van;	V 109		

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-They arrived at the park between 1:00 pm-1:30 pm and left the park a couple of hours later and returned to the facility;
-She confirmed the date of the park outing was on 2/24/19 by a review of her calendar;
-She and Staff #7 decided to take the Clients #1, #2 and FC #3 to the park because they had no behaviors earlier that day;
-Clients #1, #2 and FC #3 swung on the swings, walked around the park and sat in the sunshine while she and Staff #2 constantly moved around;
-She stated they "watched the clients the whole time" they were at the park;
-She did not see FC #3 put anything in his pockets;
-She had no knowledge whether Staff #2 saw FC #3 picking up objects off the ground at the park;
-FC #3 went to the restroom at the park twice for a "few minutes" and she watched him go into and out of the restroom each time;
-She stated that normally Clients #1, #2 and FC #3 would have their pockets emptied with staff scanning them for objects such as metal when they returned to the facility from their school or day program;
-She and Staff #2 did not take these actions with these clients after their return from the park on 2/24/19;
-She was not aware FC #3 had cut himself on 2/24/19 until she came into work on 2/27/19.

Interview on 4/15/19 with QP #4 revealed:
-She filled in occasionally as staff at the facility;
-Her primary job responsibility was paperwork and included updating each client's treatment plan after a client had their CFT meeting;
-The Licensee/QP #1 provided her with the written CFT meeting notes to update client plans;
-FC #3's safety plan was for him to be monitored

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at all times by staff;
-She had not included in his plan for his bedroom door to be kept opened;
-She had not included in his plan that FC #3 was to have his pockets emptied and scanned for objects when he returned to the facility;
-She had incorrectly documented FC #3's treatment plan with 2 reports of verbal threats of self-harm on 2/14/19 and 2/21/19, 3 "respites" (hospitalizations) of self-harm behavior and 3 elopement incidents.

Interview on 4/8/19 with the Licensee/QP #1 revealed:
-The glass from the backyard of the facility had been cleaned up after FC #3's 1/20/19 admission to a local hospital;
-FC #3 had "several incidents" of behaviors since his readmission;
-FC #3's Local Management Entity (LME) Care Coordinator recommended the weekly individual therapy be set up for FC #3 before his readmission and he (the Licensee/QP #1) set the therapy up with a local mental health provider;
-FC #3 went to his weekly individual therapy appointments after school and day treatment from 2/1/19 until he was discharged from the facility;
-He may have had 1 or 2 appointments rescheduled because the therapists at the provider agency changed;
-FC #3 was suspended from school around 3/5/19 because of aggressive behaviors toward school staff;
-He attended an alternative school until he was discharged;
-FC #3 was discharged on 3/29/19 because "he was a danger to himself;"
-He stated he could not describe all of FC #3's behavioral incidents since his readmission on

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V 109	Continued From page 13 1/30/19 because "the incidents all ran together" and the reports were filed for review in FC #3's record; -FC #3's most recent behavior occurred on 3/16/19 and involved property damage at the facility; -He (the Licensee/QP #1) was seated at the dining table and saw FC #3 upset as he (FC #3) ran out the facility and into the backyard where he threw a rock and broke the glass out of the barn window which faced the facility; -He secured a wood board over the barn's side window that FC #3 broke prior to his 1/30/19 readmission and had a board to cover this window; -3/16/19, he notified local law enforcement about FC #3 having broken the barn window and a charge of property damage was filed against FC #3; -He did not see FC #3 pick up any glass after he broke this window; -He did not know what led up to FC #3's behavior that triggered the property damage; -He cleaned up all the glass on the ground after FC #3 broke the 2nd window; -He did not know the exact date of FC #3's self-harming (cutting) behaviors and he would have to contact the HM/QP #2 and Staff #2 for more information. Interview on 4/10/19 with the Licensee/QP #1 revealed: -He was not at the local park on 2/24/19 to know if FC #3 picked up objects and was not there to supervise him when he went to the restroom; -There was not another male who could have accompanied FC #3 to the restroom to have supervised him; -He was certain Staff #2 and QP #3 did their best supervising the 3 clients at the park;	V 109		

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V 109	Continued From page 14 -There was "no way" FC #3's cutting himself could have been prevented on 2/24/19; -FC #3 tended to cut himself with superficial cuts to seek the attention of others; -He had been working with FC #3's Care Coordinator since his readmission for placement in a higher level of care. Interview on 4/9/19 with FC #3's LME Care Coordinator revealed: -She was aware of FC #3's self-harming behaviors on 2/24/19 and 3/9/19; -FC #3 received weekly individual therapy; -She thought staff had increased their supervision of FC #3 and were learning to do different things with him like talking with him more about his feelings to prevent his behavior; -In FC #3's last PRTF admission, "they were still trying to find interventions or treatment that worked for him." Interview on 4/15/19 with FC #3's Juvenile Probation Officer (PO) revealed: -3/5/19, FC #3 had a physical altercation with a teacher at school which resulted in him being suspended from school for 10 days and he was transferred to a local alternative school until he was discharged; -3/6/19, a CFT meeting was held and the team talked about FC #3's continued self-harming behaviors despite his weekly individual therapy and that he needed a higher level of care; -He stated he had in his notes that FC #3's father came by the facility at some point prior to 3/5/19 and brought some clothing to FC #3 without seeing him which triggered FC #3's behavior at school. This deficiency is cross-referenced into 10A NCAC 27G .1701-Scope (V293) for a Failure to	V 109		

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V 109	Continued From page 15 Correct the Type A1 rule violation.	V 109		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional.	V 110		

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This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure 1 of 1 audited paraprofessional staff (Staff #2) demonstrated competency in their knowledge, skills and abilities required by the population served. The findings are:

Review on 4/18/19 of Staff #2's personnel record revealed:
-Hire date: 4/18/18
-Position: Paraprofessional
-4/18/18, a written and signed job description with job responsibilities that included verbal and physical crisis interventions to clients by staff and counseling as needed;
-There were written Qualified Professional (QP) supervisory notes dated 1/22/19, 2/21/19, 3/26/19 and 4/3/19 and were signed by the Home Manager/Qualified Professional (HM/QP #2);
  -Staff #2 had a supervision goal to increase her knowledge of client diagnoses and treatment goals.

Review on 4/8/19 of 4 of 4 written incident reports for FC #3 in the North Carolina Incident Response Improvement System (IRIS) from 2/24/19-3/16/19 revealed:
-The 4 reports had no specific staff who were identified in relation to each incident except for the HM/QP #2 who completed the reports and the Licensee/QP #1 who authorized each IRIS report;
-The 2/24/19 incident report had FC #3 being observed by staff putting objects into his pockets and followed by staff having asked FC #3 to remove the contents from his pockets and his continued refusal to comply with staff requests;
  -This report did not indicate whether the staff notified the Licensee/QP #1 or called for local law enforcement's assistance to the park after FC #3 refused to remove his pocket contents and before

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he was returned with Clients #1 and #2 on the van to the facility.

Review on 4/8/19 of FC #3's record revealed:
-Printed progress notes that were written by staff and ranged in dates from 2/24/19 to 3/16/19;
-Staff #2's note dated 2/24/19 at 5:30 pm contained no statements that she observed FC #3 picking up objects while at a local park and placing the objects in his pockets;
-Her note did not include her having observed FC #3's behavior in the backyard with the bottom of an aluminum soda can;
-Her note was that she observed "surgical marks" on FC #3's left arm while outside and he was brought indoors and had First Aid applied by Staff #2;
-FC #3 went to his bedroom, Staff #2 checked on him and found he had cut himself on glass that he said he picked up earlier at the park.

Interview on 4/8/19 with Staff #2 revealed:
-She had worked one year as staff and was familiar with FC #3 and his behaviors that included self-harm with objects when he thought about his biological parents and wanted to be in a family setting like a "normal kid;"
-FC #3's safety plan required staff to monitor him when he was present at the facility before and after his day program and staff were to look for possible objects FC #3 could use as weapons to harm himself;
-His safety plan included keeping his bedroom door open any time he was in his room;
-Keeping his door opened had not been an issue before 2/24/19 because FC #3 did not usually spend more than a few minutes in his bedroom;
-The HM/QP #2 told her FC #3's bedroom door was to be kept open when he was in his room;
-FC #3 knew the opened bedroom door was a

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V 110	Continued From page 18 part of his safety plan because he got mad when he was told the door had to be left opened; -FC #3 had cut himself a couple of times on her shift; -2/24/19 at approximately 5:30 pm, FC #3 and Client #1 were in the backyard with her supervision; -FC #3 "threw" the bottom of an aluminum soda can on the ground; -She stated, "The neighbors are always throwing their trash over the fence and into the yard;" -She knew it was the bottom of a soda can because she walked over to FC #3, saw his left arm with "small surgical marks" and she picked up the soda can bottom; -She took him inside and applied first aid to his arm which had some blood and needed a small adhesive bandage; -FC #3 told her he had cut his arm with the bottom of the soda can because he was thinking about his family and got upset; -After the first aid was applied to FC #3, he went into this bedroom for a few minutes which she thought was an unusual amount of time for him; -She entered his room "after a few minutes" and saw him cutting himself with a piece of glass which he said he picked up earlier in the day from the park; -She was not going to "struggle" with FC #3 when he refused to turn the glass over to her; -Local law enforcement came to the facility, conducted a search of FC #3 and found him with a piece of glass from his pocket, a plastic container of matches, cigarette butts and a cigar tip; -He was taken to a local hospital by local law enforcement; -She stated they (Clients #1, #2 and FC #3)	V 110		

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V 110	Continued From page 19 had not gone to a park on 2/24/19 but had gone to the park the Sunday prior to 2/24/19, which would have been 2/17/19, with her and Staff #7; -3/9/19, at approximately 5:12 pm, she went into FC #3's bedroom and reminded him that closing his door was a violation of his safety plan; -She saw FC #3 seated on the floor with his left arm raised up and his arm was bleeding to the point she applied pressure to his arm to control the bleeding; -She did not know what FC #3 cut his arm with because he said he had already disposed of "it;" -FC #3 later said he cut himself with a piece of glass but he did not say where he got the glass or how he disposed of the glass; -Local law enforcement came and FC #3 was taken to a local hospital; -She saw him at the facility the next morning around 10:00 am when she came into work and he seemed fine. Interview on 4/10/19 with QP #3 revealed: -2/24/19, Clients #1, #2 and FC #3 were taken to a local park by her and Staff #2 on the facility van; -They arrived at the park between 1:00 pm-1:30 pm and left the park a couple of hours later and returned to the facility; -She confirmed that date of the park outing on 2/24/19 by a review of her calendar; -She and Staff #7 decided to take the Clients #1, #2 and FC #3 to the park because they had no behaviors earlier that day. Interview on 4/8/19 with the HM/QP #2 revealed: -She told FC #3 that he was to sleep with his bedroom door opened as this was a part of his safety plan; -Staff were to make sure FC 3's bedroom door was opened when he was in his room for	V 110		

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V 110	Continued From page 20 increased staff supervision of him; -She was responsible for providing clinical supervision to Staff #2 that included monthly meetings to help Staff #2 increase her knowledge about the clients' diagnoses, behaviors, and any changes or recommendations in the clients' care that came from therapists, doctors and other team members; -Staff #2 could be supervised by the Licensee/QP #1, QP #3 and/or QP #4 when these QPs were at the facility with her and/or other direct care staff; -If Staff #2 told her what object FC #3 used to self-harm on 3/9/19, she did not remember; -She went by the staff written notes about client behaviors to complete the IRIS reports. Interview on 4/10/19 with the Licensee/QP #1 revealed: -He was certain Staff #2 and QP #3 did their best supervising the 3 clients at the park; -There was "no way" FC #3's cutting himself could have been prevented on 2/24/19. This deficiency is cross-referenced into 10A NCAC 27G .1701-Scope (V293) for a Failure to Correct the Type A1 rule violation.	V 110		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include:	V 112		

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V 112	Continued From page 21 (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement treatment strategies that minimized the reoccurrence of a client's self-harming behaviors and ensured a continuous safe and supervised treatment approach for 1 of 1 former client (FC #3). The findings are: Review on 4/8/19 of Former Client (FC #3)'s record revealed: -He was 14 years old, readmitted on 1/30/19, and discharged on 3/29/19; -His diagnoses were Oppositional Defiant Disorder (ODD), Attention-Deficit Hyperactivity Disorder (ADHD)-combined, Major Depression, Cannabis Abuse; -His treatment plan was updated on 2/4/19 and 3/18/19 and included:	V 112		

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-a safety plan for staff to:
-identify FC #3's warning signs of an impending aggressive or frustrated episode and to know what precautions to take to ensure safety for him and others;
-"immediately" contact 911 emergency service for medical or police assistance if he displayed aggressive or destructive behaviors;
-"assess the area and observe any object(s) as soon as possible;"
-a behavioral plan for staff to "remove objects from the environment, which [FC #3] could use as a weapon;"
-a crisis prevention and intervention plan with staff strategies for FC #3 to:
-be encouraged to express his feelings and thoughts when he was argumentative, aggressive or impulsive in his behaviors;
-be monitored to ensure he was safe and he was away from any object that could be used by him to self- harm or harm others;
-have Child and Family Team (CFT) meetings to identify strategies that worked and did not work;
-a 2/4/19 "self-harm goal" with strategies was added to the treatment plan for staff to check FC #3's bedroom for objects that could be used to self-harm and to follow FC #3's safety and crisis plans if and when he became a danger to himself and/or others;
-a 3/18/19 written request for psychiatric residential treatment facility (PRTF) admission to assist FC #3 with his mental health and behaviors due to self-harming and elopement behaviors;
-There were no clear and written strategies in FC #3's safety plan that specified the precautions staff needed to take with FC #3 to minimize his aggressive behaviors, frustration and embarrassment;
-His updated treatment plan did not include

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additional strategies in his safety, behavior and crisis plans for his bedroom door to be kept opened while he was in his room, and the use, frequency and conditions in which FC #3 would be required to have his clothes' pockets emptied and his person scanned for objects;
-He had a diagnosis and goal related to cannabis abuse but here were no strategies included in his plan that addressed his problem of tobacco use.

Review on 4/8/19 of written daily staff notes for FC #3 from 2/24/19 to 3/16/19 revealed:
-No staff notes were made available for review that indicated FC #3 had his bedroom searched by staff for objects that could be used as weapons after the 2/24/19 self-harm goal was added to his plan;
-No staff documentation was found of occasions in which FC #3 had emptied the contents of his clothing pockets and he was scanned for metal objects after he returned from school, his day program and/or from outdoor activities.

Interview on 4/10/19 with FC #3 revealed:
-He cut himself with a piece of glass in 2/2019 that he found at a local park while on an outgoing with his housemates and Qualified professional (QP #3) and Staff #2;
-He had difficulty recalling an exact date but knew he went to the local park on a Saturday or Sunday;
-He picked up a piece of glass, a pack of matches and cigarette butts from the park ground near the woods and placed these items in his pocket;
-Staff #2 and Qualified Professional (QP#3) did not see him pick up the items he had in his pocket;
-These staff had not asked him to remove the items in his pockets because they did not see him

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pick anything up;
-He was not asked by any staff to empty his pockets and he did not have a scanner used on him after he returned from the park;
-He stated "the only time they did searches was after school and back at the home;"
-He waited until later that evening on 2/24/19 when he was in his bedroom with the door closed to cut himself;
-Staff #2 opened the door and saw his arm bleeding;
-He told Staff #2 he got the glass from the park and he refused to give the glass to her;
-Staff #2 called local law enforcement and he turned over the glass, matches and cigarette butts;
-He was taken to a local hospital by law enforcement where he stayed overnight and returned to the facility on 2/25/19;
-A 2nd self-cutting incident occurred in 3/2019 with a razor he had and told Staff #2 he disposed of it;
-His response to where he found the razor was "I just found it" without additional information provided;
-He stated Staff #2 came into his room and took the razor away from him, called the Licensee/QP #1 and 911 emergency medical service (EMS) and he was transported by EMS to a local hospital;
-He stated that he had an incident in 3/2019 where he ran outside the facility and busted the other barn window;
-He got angry because Staff #1 "provoked" him and he felt like he could not escape so he ran outside;
-He felt Staff #1 liked to "play around" with him ("made fun of") when he was upset;
-He talked disrespectful to Staffs #1 and #2 because he was tired of being told what he could

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and could not do;
-He did not want to go back to the facility;
-He wanted to be placed in a regular foster care home.

Interview on 4/15/19 with a Licensed Professional Counselor (LPC) who was contracted by the facility revealed:
-She provided group therapy once every 2 weeks at the facility to Clients #1, #2 and FC #3;
-She did not communicate with FC #3's individual therapist because the Licensee/QP #1 usually communicated with the therapist;
-FC #3 participated in her group therapy sessions about wanting a family and to be a "normal kid;"
-His self-harming behaviors were not addressed as part of the group therapy sessions;
-FC #3's individual outpatient therapist and treatment team were addressing these behaviors;
-She did not know any specifics of FC #3's Child and Family Team (CFT) meetings because she was not invited to these team meetings;
-The only issue she recalled discussing with the Licensee/QP #1 was FC #3 needed a higher level of care to better manage his symptoms related to the self-harming behavior.

Interview on 4/15/19 with QP #4 revealed:
-She updated each client's treatment plan after a client had their CFT meeting;
-The Licensee/QP #1 provided her with the written CFT meeting notes to update client plans;
-FC #3 had 2 incidents in 2/2019 in which he verbally threatened to harm himself by cutting his arm;
The 2 incidents were on 2/14/19 and 2/21/19;
-FC #3 went to a local hospital on 2/14/19 as a result of "disrupting his placement" by his verbal threats of self-harm;
-She did not see any hospital paperwork for his

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V 112	Continued From page 26 2/14/19 hospital visit; -FC #3 had a crisis plan as part of his treatment plan that involved the following strategies: -He was to be asked by staff to clarify his verbal threats of self-harm; -If he continued making threats to self-harm, staff were to notify the Licensee/QP #1 and have FC #3 escorted by local law enforcement to a local hospital for an evaluation of suicidal ideation; -FC #3's "habit" of self-harm was "attention-seeking behavior;" -She had not included specific strategies in FC #3's crisis plan for his bedroom door to be kept open when he was in his room or added in the plan that he was to empty his pockets of all contents when he returned from school and outings; -FC #3's elopements in 3/2019 from the facility were to smoke cigarettes; -He had a goal and strategies to work on his prior use of marijuana and the same goal and strategies for his past marijuana could be used for his tobacco use. Interview on 4/15/19 with the Home Manager/QP #2 revealed: -She was not responsible for updating client treatment plans; -She reviewed the client treatment plans for changes and informed staff of any recommendations or changes in the client treatment plans; -QP #3 had the dates incorrect in FC #3's treatment plan with regard to his 2/24/19 incident of self-harm because her review of staff notes on 2/4/19, 2/14/19 and 2/21/19 had him with no aggressive or self-harming behaviors; -FC #3 eloped from the facility on 2 occasions, 3/10/19 and 3/16/19, to smoke cigarettes at a	V 112		

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V 112	Continued From page 27 local store because he said he could not smoke cigarettes at the facility; -She talked with FC #3 about not smoking but, as far as she knew, he did not have a goal or strategies related to tobacco use in his treatment plan. Interview on 4/10/19 with the Licensee/QP #1 revealed: -He reviewed the treatment plans for any new updates and for the clients' legal guardians to review and sign; -QP #4 was responsible for the updates to the clients' treatment plans; -FC #3's treatment plan was updated on 3/18/19 with a request for his admission to a psychiatric residential treatment facility because of FC #3's verbal and physical threats and his defiant behaviors continued in school and at the facility; -He had been seeking a higher level of care for FC #3 since he returned to the facility in 2/2019. This deficiency is cross-referenced into 10A NCAC 27G .1701-Scope (V293) for a Failure to Correct the Type A1 rule violation.	V 112		
V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of	V 293		

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V 293	Continued From page 28 this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to a community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care.	V 293		

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This Rule is not met as evidenced by:
Based on record review and interview, the facility's Qualified Professionals (Licensee/QP #1, House Manager/QP #2, QP #3 and QP #4) failed to design services that minimized the reoccurrence of client behaviors and ensured a continuous safe, supervised and least restrictive environment to support 1 of 1 former clients (FC #1) to gain the skills needed to step down to a less intensive treatment setting. The findings are:

CROSS-REFERENCE: 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) Based on record review and interview, the facility failed to ensure 3 of 3 audited Qualified Professionals (Licensee/QP #1, House Manager (HM)/QP #2, QP #3 and QP #4) demonstrated the knowledge, skills and abilities required by the population served.

CROSS-REFERENCE: 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110)
Based on record review and interview, the facility failed to ensure 1 of 1 audited paraprofessional staff (Staff #2) demonstrated competency in their knowledge, skills and abilities required by the population served.

CROSS-REFERENCE: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112)
Based on record review and interview, the facility failed to develop and implement treatment strategies that minimized the reoccurrence of a client's self-harming behaviors and ensured a continuous safe and supervised treatment

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approach for 1 of 1 former client (FC #3).

CROSS-REFERENCE: 10A NCAC 27G .0101 Least Restrictive Alternative (V513)
Based on record review, observation and interview, the facility failed to use the least restrictive approaches to ensure a safe and respectful environment for 1 of 1 former client (FC #3) to gain the skills needed to step down to a less intensive treatment program.

Review on 4/16/19 of an initial Plan of Protection signed and dated 4/15/19 by the Licensee/Qualified Professional (Licensee/QP #1) revealed:
What will you immediately do to correct the above violations in order to protect clients from further risk or additional harm? Describe your plans to make sure the above happens. "Per IRIS (NC Incident Response Improvement System) submitted by [the facility], staff accompanied [FC #3] to a public park. While being supervised in the park, staff observed client [FC #3] putting an unknown object in his pocket. Staff asked client [FC #3] to remove object from his pocket. Client [FC #3] refused to remove unknow object from his pocket. To avoid a public confrontation or worst, staff took client back to group home without incident. Upon arrival to the group home, staff continued to try to use de-escalation methods to convince client [FC #3] to remove object from his pocket. After being prompted several more times to remove object form his [FC #3] pocket, client [FC #3] removed what appeared to be a piece of glass and cut his arm in front of staff. Staff unsuccessfully attempted to remove glass from Client [FC #3]'s hand and call police for assistants. Client [FC #3] was taken to the hospital for a psychiatric evaluation. Each staff member employed by [the facility] has met

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the educational requirements and have received all required trainings mandated by the NC Department of Health and Human Services as it relates to .1700 group homes. The staff of [the facility] will continue to ensure the safety of its clients and adhere to the PCP (Person-Centered Profile) safety plan of each client."

Review on 4/16/19 of an amended Plan of protection signed and dated 4/16/19 by the Licensee/Qualified Professional (Licensee/QP #1) revealed:
What will you immediately do to correct the above violations in order to protect clients from further risk or additional harm? Describe your plans to make sure the above happens. "[The facility] professionals and associate professionals demonstrated knowledge, skills, and abilities required by the population served, particularly [FC #3]. All [the facility] professionals and associate professionals have the analytical, decision making and communication skills to serve [FC #3]. Each staff member employed by [the facility] has met the educational requirements and have received all required trainings mandated by the NC Department of Health and Human Services as it relates to .1700 group homes.
[The facility]'s personalized safety plan for client [FC #3] outlines the steps to be taken in order to protect the client. The safety plan states:
'[FC #3]'s Parent(s), Natural Supports, Group Home Staff are to notify physicians and/or specialists if [FC #3] reports feelings of homicidal or suicidal.
If [FC #3] becomes aggressive towards others or displays destructive behaviors, and immediate medical attention is required his Group Home Staff, Parent(s) and Natural Support, MH (Mental Health) provider, Authority Figures will immediately contact 911 for medical or police for

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assistance.
In order to minimize the dangers of his aggressive behaviors, frustration, or embarrassment due to his diagnoses and symptoms associated with his diagnosis; Group Home Staff, Parent(s) and Natural Supports should be educated with identifying the warning signs of an impending episode and what safety precautions should be taken to ensure safety for him and/or others.
[FC #3] will need a designated area within the home setting, school to enhance his ability to self-calm to enhance his ability to decrease an outburst or event vent frustrations appropriately without aggression. It is imperative to assess the area and observe any object(s) as possible weapons.
[FC #3] will speak loudly or demand to be left alone when he feels embarrassed or frustrated. [FC #3] likes drawing, sports and music as a coping skill. [FC #3] will possibly threaten to physically harm to others. [FC #3] face will be a solid appearance and stare without verbalization. [FC #3] should be monitored when using self-calming strategies.'
[FC #3] exhibited no signs of aggression or destructive behaviors before arriving to the park. [The facility] staff is trained to notice the warning signs of an impending episode by [FC #3]. After thoroughly sweeping and looking at the area where [FC #3] played in the park. While being supervised in the park, staff observed client [FC #3] putting an unknown object in his pocket. Staff asked client [FC #3] to remove object from his pocket. [The facility] staff acted on their knowledge of [FC #3] homicidal and suicidal inclinations. [FC #3] refused to put the unknown object down.
To avoid a public confrontation or worst, staff took client back to group home without incident. Upon

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arrival to the group home, staff continued to try to use de-escalation methods to convince client [FC #3] to remove object from his pocket. Staff employed calming strategies to try and remove the object from [FC #3] and attempt to protect [FC #3], other clients and staff. After being prompted several more times to remove object form his pocket, [FC #3] removed what appeared to be a piece of glass. [FC #3] then immediately cut his arm in front of staff. Staff unsuccessfully attempted to remove glass from client [FC #3]'s hand. The police were called for assistance. [FC #3] was taken to the hospital for a psychiatric evaluation. The staff of [the facility] will continue to ensure the safety of its clients and adhere to the PCP safety pan of each client.
[The facility]'s safety plan demonstrates (staff) understanding of [FC #3]'s need and propensity for dangerous behaviors. [The facility] staff were balancing the need to safely deescalate the situation with their need to immediately remove the unknown object from [FC #3]. In this situation, all procedures were followed. [FC #3] did not exhibit any behavior which would indicate that law enforcement needed to be called any sooner. [FC #3] was not being threatening. [FC #3] was holding an unknown object. [FC #3]'s action became unpredictable and dangerous within seconds. In the future, staff will continue to follow all State and local guidelines. [The facility] will ensure that safety protocols are in accordance with those applicable laws."

Former Client (FC#3), age 14, was readmitted on 1/30/19 and diagnosed with Conduct Disorder, Attention-Deficit Hyperactivity Disorder (ADHD), Major Depression and Cannabis Abuse. He was discharged on 3/29/19. He had a history of self-harming and aggressive behaviors. Since his readmission, FC #3 had 2 continued self-harming

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V 293	Continued From page 34 (cutting) behaviors with objects he found and kept in his possession. The first occasion was on 2/24/19 in the facility's backyard with the bottom of an aluminum soda can and after a local park outing and was later followed by cutting his arm with a piece of glass he picked up at the park. The second occasion occurred on 3/9/19 in his bedroom after a few minutes of having his bedroom door closed and without continuous supervision. There were discrepancies in the written facility reports on FC #3 completed by the House Manager/Qualified Professional (HM/QP #2) and verbal accounts from staff (the HM/QP #2, QP #3, and Staff #2) and FC #3 as to whether FC #3 was observed by staff with objects he picked up at a local park and used to self-harm. There were discrepancies between the written incident reports and verbal accounts from HM/QP #2 and Staff #2 as to whether they observed FC #3's elopements on 3/10/19 and 3/16/19. These discrepancies made it difficult to determine the accuracy and immediacy of staff attempts (strategies used) with FC #3 to prevent a reoccurrence in his behaviors. FC #3's safety, behavior and crisis plans gave consistent instructions to observe the environments FC #3 was in for objects that could be used by him to self-harm and to remove the objects. His 2/4/19 self-harm goal in his treatment plan allowed staff to have his bedroom searched for possible self-harming objects but there was no evidence his room was searched by staff prior to his self-harming behaviors on 2/24/19 and 3/9/19. There were additional safety measures for FC #3 (keeping his bedroom door opened when he was in his room and emptying his pockets and having his body scanned for possible weapons) which were identified by the HM/QP #2 and Staff #2 but they were not included in FC #3's treatment plan. These measures were not applied consistently by	V 293		

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V 293	Continued From page 35 staff with FC #3 as he was allowed to close his bedroom door on 3/9/19 and on 3/10/19 and he emptied his clothing pockets and had his body scanned for objects after school but not after a community outing. As a result, FC #3 continued to self-harm and he was discharged to a higher level of care. This deficiency constitutes a Failure to Correct the Type A1 rule violation originally cited for serious neglect. An administrative penalty of $500.00 per day is imposed for failure to correct within 23 days.	V 293		
V 513	27E .0101 Client Rights - Least Restictive 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	V 513		

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V 513	Continued From page 36 trained in its use. This Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to use the least restrictive approaches to ensure a safe and respectful environment for 1 of 1 former client (FC #3) to gain the skills needed to step down to a less intensive treatment program. The findings are: Review on 4/8/19 of Former Client (FC #3)'s record revealed: -He was 14 years old, readmitted to the facility on 1/30/19 and was discharged on 3/29/19; -His discharge led to a 2nd psychiatric residential treatment facility (PRTF) admission; -He had a history of self-cutting and property damage behaviors; -An updated treatment plan dated 3/18/19 contained safety, behavior and crisis plans but did not contain clear and written strategies for use with FC #3 that could be measured for the effectiveness in preventing a reoccurrence of his self-harming and elopement behaviors; -His 3/18/19 updated treatment plan included a written request for PRTF admission to assist FC #3 with his mental health and behaviors due to continued self-harming and elopement incidents. Review on 4/8/19 of written incident reports for FC #3 in the North Carolina Incident Response Improvement System (IRIS) from 2/24/19-3/16/19 revealed: -4 reports with incident dates of 2/24/19, 3/9/19, 3/10/19 and 3/16/19; -Each of these reports had local law enforcement	V 513		

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involvement to address his self-harming and elopement behaviors with written incident prevention statements that FC #3 needed a higher level of care;
-An additional incident prevention statement in the 2/24/19's report indicated that because of FC #3's self-harming behavior, clients with this behavior would not be allowed to participate in an outing to a park;
-2 of 2 of the self-harming behaviors resulted in FC #3 being transported to a local hospital for medical and psychiatric evaluations;
-1 of 2 incidents of FC #3's elopements had him with escalated aggression which led to property destruction at the facility and resulted in a legal charge of property damage against him.

Review on 4/8/19 of FC #3's written discharge summary revealed:
-He continued to have self-harming behaviors and episodes of elopement;
-He was verbally and physically defiant with his directives from staff;
-He was redirected by staff 10 to 15 times in 5 out of 7 days due to arguing, lying, manipulating others and influencing his peers with negative behaviors;
-He refused to accept responsibility for his behaviors;
-He made verbal threats against school personnel which resulted in his suspension from school;
-His discharge plan was an admission to a psychiatric residential treatment facility (PRTF) and to follow recommendations of his PRTF team.

Interview on 4/10/19 with the Licensee/QP #1 revealed:
-He had been working with FC #3's Care Coordinator since his readmission for placement

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V 513	Continued From page 38 in a higher level of care. This deficiency is cross-referenced into 10A NCAC 27G .1701-Scope (V293) for a Failure to Correct the Type A1 rule violation.	V 513		