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
	MHL060968	A. BUILDING: _____ B. WING _____	R 04/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDER YOUTH NETWORK - CHARLOTTE DAY T	6220-D THERMAL RD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual, complaint, and follow up survey was completed on April 30, 2019. The complaint was unsubstantiated (Intake # NC150694). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1400 Day Treatment for Children and Adolescents with Emotional or Behavioral Disturbances.	V 000	DHSR - Mental Health MAY 2 0 2019 Lic. & Cert. Section	

V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) In a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) Separately for external and internal use ;(E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. This Rule is not met as evidenced by: Based on interview, record review, and observation, the facility failed to maintain secure	V 120	**What measures will be put in place to correct the deficient area of practice.** • At the end of each day Program Manager or another Qualified Professional trained in medication administration assigned by program manager will do check to ensure that all medication counts are accurate. • All Charlotte Day Treatment staff will be trained in Medication administration. • Each classroom staff will be responsible for their consumer's medication within their classroom. One staff will give out the meds, and the other staff will back them up to ensure counts are correct. **Describe your plans to make sure the above happens.** • Once a week, RN nurse will go and check medications, medication counts and MAR sheets to ensure that everything meets protocol. • If counts are off the nurse will immediately report to Program Manager and Executive Director and fill out incident report. **Who will monitor the situation to ensure it will not occur again.** • All the items on this plan will be monitored by the Program Manager.	4/30/19 5/13/19 5/20/19 5/2/19 5/2/19

Division of Health Service Regulation

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

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V 120	Continued From page 1 Safe storage of medication 4 of 6 audited current clients (Clients #2, #3, #4, and #5). The findings are: Review on 4/24/19 of Client #2's record revealed: -Admission date 8/9/18; -Diagnoses of Circadian Rhythm Sleep Wake Disorder, Separation Anxiety Disorder, Attention Deficit Hyperactivity Disorder (ADHD), History of Physical Abuse; -8 years old; -Physician's order dated 12/5/18 for Vyvanse (treatment of ADHD) 20mg 1 tab at 12:00pm; -Count sheet for Vyvanse 20mg revealed there were 8 Vyvanse 20mg pills present on the morning of 3/21/19. One was administered at 11am on that date; -Count sheet for Vyvanse 20mg included the notation dated 3/21/19 "Counted by PI (Performance Improvement) and count was off by 2 pills" with the signature of the Performance Improvement Manager (PIM). Review on 4/24/19 of Client #3's record revealed: -Admission date 8/6/18; -Diagnoses of Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, Adjustment Disorder; -6 years old; -Physician's order dated 10/16/18 for Adderall XR (treatment of ADHD) 15mg 1 capsule at 12:00pm; -Count sheet for Adderrall XR 15mg revealed there were 14 Adderall XR 15mg pills present on the morning of 3/21/19. One was administered at 11am on that date; -Count sheet for Adderrall XR15mg included the notation dated 3/21/19 "Count was off by 1 capsule" with the initials of the PIM. Review on 4/24/19 of Client #4's record revealed:	V 120		

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V 120	Continued From page 2 -Admission date 12/27/18; -Diagnoses of Adjustment Disorder with Mixed Disturbance of Emotions/Conduct, Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, Autism Spectrum Disorder; -10 years old; -Physician's order dated 1/16/19 for Methylphenidate (treatment of ADHD) 10mg 2 tabs at 10:00am and 2:00pm; -Count sheet for Methylphenidate 10mg revealed there were 29 pills in the facility just prior to review on 3/21/19 by the PIM. The date of previous administration is unclear because the dates had been crossed out and whited out; -Count sheet for Methylphenidate 10mg included a notation dated 3/21/19 "count off by 6 tablets" with the initials of the PIM; -Count sheet for Methylphenidate 10mg revealed there were 62 pills in the facility just prior to review on 4/24/19 by the PIM; -Count sheet for Methylphenidate 10mg included a notation dated 4/24/19 "counted by PI and count was off by 4 pills." Review on 4/24/19 of Client #5's record revealed: -Admission date 3/11/19; -Diagnoses of Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, Childhood Onset Fluency Disorder (Stuttering); -13 years old; -Physician's order dated 4/2/19 for Focalin XR (treatment of ADHD) 30mg 1 cap at 9:00am and Focalin 5mg 2 caps at 1:00pm; -Count sheet for Focalin XR 30mg revealed there were 12 pills in the facility on 3/21/19. One pill was administered at 9:00am; -Count sheet for Focalin XR 30mg included a notation dated 3/21/19 "Count off by 1 capsule" with the initials of the PIM; -Count sheet for Focalin 5mg revealed there was	V 120		

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V 120	Continued From page 3 47 pills in the facility on 3/21/19. Two pills were administered at 1:00pm; -Count sheet for Focalin 5mg included a notation dated 3/21/19 "count was off by 1 pill" with the initials of the PIM; -Count sheet for Focalin 5mg included multiple cross outs and pill count re-entries on the count sheet with notations of "correct count" for each day appearing that medication counts were off for 8 consecutive dates of medication administration from 3/28/19 through 4/5/19. Review on 4/24/19 of Staff #10's record revealed: -Hire date 9/10/18; -Hired as Mental Health Counselor. Review on 4/23/19 of the facility's Incident Reports revealed: -Level 1 incident report dated 3/21/19 for Client #2 revealed that during an internal review of medications, it was discovered that the medication count was off by 1 pill for Vyvanse 20mg; -Level 1 incident report dated 3/21/19 for Client #3 revealed that during an internal review of medications, it was discovered that the medication count was off by 1 pill for Adderall 15mg; -Level 1 incident report dated 3/21/19 for Client #4 revealed that during an internal review of medications, it was discovered that the medication count was off by 5 pills for Methylphenidate 10mg; -Level I incident report dated 3/21/19 for Client #5 revealed that during an internal review of medications, it was discovered that medication counts were off by 1 pill each for Focalin XR 30mg and Focalin 5mg. Review on 4/26/19 of the facility's Policy on	V 120		

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V 120	Continued From page 4 Storage, Disposal and Control of Medications (Policy 4.8) effective 1/1/1998 with most recent update on 5/25/10 revealed: -" ...Schedule II Controlled Medications: (11) Upon delivery of Schedule II drugs, an authorized staff member verifies receipt by adding the count and initials to the Controlled Drugs Record. Schedule II drugs will be placed in the medication closet immediately; (12) Schedule II drugs are not to be removed from locked storage until time of administration and must be signed out at that time; (13) Two staff members shall count all controlled medication on a regular basis verify count is correct. The two staff members sing the Controlled Drugs Record signifying count is accurate. This record is maintained for three years; (14) If there is a discrepancy in the count, staff will make every effort to resolve the discrepancy immediately. If the discrepancy cannot be resolved, it will be reported through the Incident Report and accompanying procedures and recorded on the Controlled Drug Record ..." Interview on 4/25/19 with Client #2 revealed: -Takes medication at the facility but does not know the name of it; -The medication is "the white pill;" -Different staff administer medication; -Never missed receiving his medication. Interview on 4/25/19 with Client #3 revealed: -Takes medication at the facility but does not know the name of it; -The medication is "the blue pill;" -Different staff administer medication; -Never missed receiving his medication. Interview on 4/25/19 with Client #4 revealed: -Takes medication at the facility but does not know the name of it;	V 120		

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V 120	Continued From page 5 -The medication is the "mint green pill;" -Different staff administer medication; -Never missed receiving his medication. Interview on 4/25/19 with Client #5 revealed: -Takes medication at the facility; -Takes "Focalin XR 30;" -Different staff administer medication; -Never missed medications at the facility because the "doctor at mental health send the paperwork." Interview on 4/25/19 with Staff #10 revealed: -Began administering medications three weeks ago; -When administering controlled substance medications, must have an additional staff present as a witness; -After administering the medication to each client, the staff must make sure to check if the client swallowed the medication. Staff must then sign the Medication Administration Record and the count sheet for any controlled substance medications. The staff witness does not sign any documents. Interview on 4/25/19 with the Case Manager revealed: -When families drop off controlled substance medications for clients, the medications must be checked in by staff trained in medication administration. The controlled substance medication pills are counted and a Control Medication Sheet is completed documenting the number of pills brought to the facility. The staff and family member each sign the Control Medication Sheet verifying the number of pills brought to the facility. Interview on 4/25/19 with the Executive Director revealed:	V 120		

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V 120	Continued From page 6 -There should never be any discrepancies between the number of pills listed on the count sheet and the actual number of pills present in the facility; -There have been discrepancies in the past several weeks; -Many staff have administered medications in the past several weeks; -Registered Nurses will be assigned to oversee medication administration, controlled substance count, and storage of medication at the facility. Observation on 4/25/19 at approximately 11:00am revealed: -Medication stored in a cabinet secured with a large padlock. The medication cabinet is located behind two locked closet doors. Review on 4/26/19 of the Plan of Protection completed by the Executive Director dated 4/26/19 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? -At the end of each day, either the Program Manager or a staff assigned by Program Manager will check to ensure that all medication counts are accurate. -All Charlotte Day Treatment staff will be training in Medication Administration. -Each classroom staff will be responsible for their consumer's medication within their classroom. One staff will give out the meds (medications), and the other staff will back them up to ensure counts are correct. Describe your plans to make sure the above happens. -Once a week, RN (Registered Nurse) will check medications, medication counts, and MAR (Medication Administration Record) sheets to ensure that everything meets protocol.	V 120		

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V 120	Continued From page 7 -If counts are off, the nurse will immediately report to the Program Manager and the Executive Director and will complete an incident report." Accurate count records and secure storage were not maintained for controlled substance Medications resulting in multiple pills of Adderall, Methylphenidate, Focalin, and Vyvanse being unaccounted for. These medications were under the control and responsibility of the facility and were prescribed for the treatment of Attention Deficit Hyperactivity Disorder for clients ranging from 6 - 13 years old. The medications have a high potential for diversion and misuse. The clients were diagnosed with mental health needs including, but not limited to, Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Adjustment Disorder, and Autism Spectrum Disorder. Missing controlled substance medication is detrimental to the clients' health, safety, and welfare in that only a limited amount of controlled substance medications can be dispensed each month. This deficiency Constitutes a Type B rule violation. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 120		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients	V 367	. **What measures will be put in place to correct the deficient area of practice.** • At the end of each day, Program Manager will meet face to face with a staff member from each group and inquire about any incidents that occurred during the day. • If any incidents occur Program manager will check to ensure documents are complete, and determine what level the incident should be under. • If the incident rises to a level 2 or 3 Program Manager will ensure that critical incident information is complete. • Program manager will ensure that the proper authorities have been contacted and notified of the incident.	4/30/19 4/30/19 4/30/19

			Describe your plans to make sure the above happens. • On 4/30/19, Executive director discussed with Program Manager the prevention steps above, and explained to him that even if an incident doesn't occur on our property we as an agency are the clinical home, and are required to ensure all documentation is completed. • On 5/20 Program Manager will complete a refresher to review incident documentation protocol with his staff to ensure that they are aware of what constitutes and incident and how to document the details. • Program Manager will complete coaching and other progressive documentation in situations in which the correct documentation procedures are not followed. **Who will monitor the situation to ensure it will not occur again.** • The Executive Director for the program will monitor the situation to ensure that it does not occur again.	

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V 367	Continued From page 8 to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of	V 367		

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V 367	Continued From page 9 Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to report all level II incidents to the Local Management Entity (LME) responsible for the	V 367		

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V 367	Continued From page 10 catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are: Review on 4/24/19 of Client #6's record revealed: -Admission date 12/6/18; -Diagnoses of Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder, Major Depressive Disorder, Generalized Anxiety Disorder, Persistent Depressive Disorder, Borderline Intellectual Functioning; -13 years old. Review on 4/24/19 of Former Client #7's record revealed: -Admission date 7/9/18; -Diagnoses of Nocturnal Enuresis, Other Specified Trauma or Stressor Disorder, Attention Deficit Hyperactivity Disorder, Borderline Intellectual Developmental Disability, Disruptive Mood Dysregulation Disorder; - 11 years old. Review on 4/23/19 of the facility's Incident Reports revealed: -Level I incident report dated 3/20/19 regarding an incident of aggression and suicidal ideation for Client #6 which resulted in a report to local law enforcement; -Level I incident report dated 3/6/19 regarding in incident of aggression and assault for Former Client #7 which resulted in a report to law enforcement and returning the client to the facility. Interview on 4/25/19 with the Executive Director revealed: -Will make sure all Level II incident reports are completed as needed in the future; -Did not realize the incident involving Former	V 367		

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V 367	Continued From page 11 Client #7 needed to be completed as a Level II incident; -Had instructed the staff to complete a Level II incident for Client #6. It must have been an oversight that staff did not complete the Level II report.	V 367		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the	V 537	**What measures will be put in place to correct the deficient area of practice.** • Formal refresher training on physical restraints will be provided to all staff on 5/20. • Self-awareness training will be provided to all staff on 5/20. • All staff will be required to complete TCI training prior to working with clients and be required to complete TCI refreshers every 6 months following employment with the company. . **Describe your plans to make sure the above happens.** • Executive Director trained as a TCI trainer has scheduled and will be conducting TCI refresher and self-awareness training on 5/20 for all staff. • All staff have received advance notification of mandatory requirement of attendance to scheduled trainings. •TCI refreshers will continue to be required for all staff every 6 months **Who will monitor the situation to ensure it will not occur again.** •Program Manager will ensure that all	

			staff complete TCI trainings and refreshers as specified by corrective action plan and as required by the company.	

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ALEXANDER YOUTH NETWORK - CHARLOTTE DAY T	6220-D THERMAL RD CHARLOTTE, NC 28211

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

V 537	Continued From page 12 course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures.(h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and(C) instructor's name.	V 537		

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V 537	Continued From page 13 (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in	V 537		

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V 537	Continued From page 14 CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and(C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on interview and record review, facility staff failed to display competency while implementing physical restraints affecting 1 of 3 audited staff members (Staff #8). The findings are:	V 537		

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V 537	Continued From page 15 Review on 4/24/19 of Client #1's record revealed: -Admission date 3/4/19; -Diagnoses of Obsessive Compulsive Disorder, Other Specific Impulse Control and Conduct Disorder, Unspecified Schizophrenia Spectrum and Other Psychotic Disorder, Unspecified Depression Disorder, Unspecified Attention Hyperactivity Disorder; -10 years old. Interview on 4/25/19 with Client #1 revealed: -Had not been restrained at the facility; -Staff #1 grabbed him by the wrist and the neck the day his most recent Child and Family Team (CFT) meeting (4/12/19), but he was not grabbed by his legs or feet. Review on 4/22/19 of Staff #8's record revealed: -Hire date 9/12/16; -Employed as Mental Health Counselor; -Completed training in Seclusion, Physical Restraint and Isolation Time-Out on 6/25/18. Review on 4/22/19 of Staff #9's record revealed: -Hire date 2/25/19; -Employed as Mental Health Counselor; -Completed training in Seclusion, Physical Restraint and Isolation Time-Out on 3/1/19. Review on 4/24/19 of the Video Surveillance of the facility for 4/12/19 at approximately 2:12 pm - 2:20pm revealed: -2:12pm: Client #1 walked out of the classroom and was redirected by staff back to the classroom. Client #1 walked into a large storage area inside the classroom; -2:19pm: Staff #8 went to talk with Client #1; -2:20pm: Staff #8 dragged Client #1 by the feet out of the classroom storage area and into the	V 537		

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V 537	Continued From page 16 actual classroom area. Staff #9 was at her side but did not touch Client #1. Client #1 kicked and attempted to fight with Staff #8. Within minutes, Client #1 and Staff #8 calmly walked from the classroom without incident. Interview on 4/23/19 with Staff #8 revealed: -Identified job responsibilities to include "provide strategies and coping skills to manage behaviors ...remove kids when aggressive or upset to process feelings on what is going on...;" -Client #1 is an attention-seeking child who has a history of self-harm, banging his head and stomping his feet and has a hard time accepting "NO;" -When Client #1 was argumentative and upset demanding to join his CFT meeting prior to the team being ready, he became upset and refused to move. Staff #8 "grabbed [Client #1] by his upper arm and took him back to classroom;" -Staff #8 and Staff #9 grabbed Client #1 by the arms and "pulled [Client #1] out of the closet;" -Client #1 eventually joined the CFT Meeting. Interview on 4/23/19 with Staff #9 revealed: -Identified job responsibilities to include "keep clients in a safe environment and in compliance with the rules;" -Client #1 was looking to enter his CFT Meeting and was upset that the rest of the CFT was not ready for him to join, so Client #1 went into a storage area for "quiet time" and refused to leave. Client #1 began to tantrum and fell to the ground. Staff #8 grabbed Client #1 by the arm and walked to another classroom. Staff #9 denied touching Client #1. Interview on 4/25/19 with the Executive Director revealed: -Staff #8 was suspended regarding another	V 537		

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V 537	Continued From page 17 matter; -Staff #9 was coached regarding the incident; -Staff will continue to be trained on appropriate physical restraints.	V 537		

Executive Director: Leonard Shinhoster 5/17/19