STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-648	A. BUILDING: _____ B. WING _____	R 05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TURN AROUND	9709 BATTEN COURT MINT HILL, NC 28227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A follow up survey was completed on 5-2-19. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents services.	V 000	DHSR - Mental Health JUN 21 2019 Lic. & Cert. Section	
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	please see attached	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Executive Director — TITLE: 6/16/19. — (X6) DATE

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V 110	Continued From page 1 This Rule is not met as evidenced by: Based on interviews and record review, 3 out of 4 staff (staff #1, #4 and the facility manager) failed to demonstrate knowledge , skills and abilities required by the populations served. The findings are: Review on 4-24-19 of the facility manager's record revealed: -Hire date of 8-22-12. -Trainings include EBPI (Evidenced Based Protective Interventions) 1-30-19, common disorders, unsafe behaviors, client rights, specific population training 8-16-12. Review on 4-29-19 of staff #4's personnel record revealed: -Hire date of 8-31-18 -Trainings include: common disorders, management of aggressive behaviors, identification of unsafe behaviors, 9-2-18, EBPI (Evidenced Based Protective Interventions) 1-23-19. Review on 4-29-19 of client #4's record revealed: -Admitted 1-26-18. -16 years old. -Diagnoses included: AD/HD (Attention Deficit/Hyperactivity Disorder), Oppositional Defiant Disorder, and Disruptive Mood Dysregulation Disorder. -Admission assessment dated 1-26-18;	V 110	please see attached	

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V 110	Continued From page 2 "discharged from a psychiatric residential treatment facility...made significant progress...needs to respect adults and use adequate coping skills...attacking mother by kicking her in the stomach requiring stitches...threatening mother and siblings." -Comprehensive Psycho Social addendum dated 1-3-18; "behaviors include sneaking, lying property destruction, unwilling to accept responsibility...past two months exponential progress...been engaged in therapy ...begun to process through physical and sexual abuse that occurred in foster home." -Person Centered Plan dated 3-15-19 revealed: Goals include; will give positive program participation as evidenced by; will comply with adult authority figures...will use anger management to avoid throwing temper tantrum, daily conflict and anger outburst...will take responsibility for her actions as evidenced by; not blaming others, accepting 'no' remain in assigned area. "Staff will monitor consumer at all times and act as appropriate role model, will monitor symptoms and help teach coping skills, help identify different emotions." -Crisis Plan included;will act out verbally...give space and supervision...talk in low voice so she does not become defensive. Review on 4-24-19 of client #3's record revealed: -Admitted 4-9-19 -14 years old -Diagnosis of Major Depressive Disorder-Single episode. -Admission assessment dated 4-9-19 revealed: Lateral move, self-injurious behavior, stealing. -Diagnostic Assessment Addendum dated 5-21-18 revealed; continues to be aggressive...was recently hospitalized due to aggressive and self	V 110	please see attached	

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V 110	Continued From page 3 injurious behavior..." -Person Centered Plan dated 4-4-19 revealed; "continues to lash out at peers and staff...attempted to run away from group home 3 times in 30 days...jumped out of the window of the group home to fight another client...Goals include; need to develop skills of controlling anger...refraining from Self-injurious behavior...will follow rules and directions of level III home. Staff will monitor, help teach appropriate coping skills, help utilize skills learned in therapy. Review on 4-24-19 of former client #5's (FC#5) record revealed: -Admitted 11-13-18 -15 years old -Diagnoses of Unspecified Impulse Control Disorder, Conduct Disorder, Unspecified Trauma and Stressor Related Disorder, and Moderate Cannabis Use Disorder. -Clinical Diagnostic Assessment dated 3-27-18 revealed: "Ran 3 times from foster homes...she and a friend took a car without permission and ran into a tree stump...history of substance abuse and running away...." -Admission Assessment dated 11-13-18 revealed; "Level II foster placement recently disrupted due to elopement behavior as well as risky and unsafe behavior...currently on probation due to driving without a license and unlawful use of a motor vehicle ." -Person Centered Plan last updated 3-11-19 revealed: currently in detention for stealing another vehicle...goals include; will comply with current conditions of probation...will participate in therapy positively as evidenced by attending scheduled therapy and addressing issues with DSS (department of social services) custody...will attend school daily...staff will monitor, help with coping skills, transport to therapy.	V 110	please see attached 	

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V 110	Continued From page 4 Finding 1. Review on 4-24-19 of IRIS (Incident Response Improvement System) report dated 4-22-19 of incident occurring 4-20-19 revealed: -"Around 8:45 an the consumer (client #3) was woke up by [facility manager] to address her morning hygiene and to clean her area as they had to take another consumer on a day visit to DSS (Department of Social Services) . The consumer refused to get out of bed but eventually went to the bathroom.... her peer asked her if she could get ready because she did not want to be late to her visit and consumer began to threaten her peer stating she did not care about her visit. This led to an argument which required staff intervention to prevent further altercation. [facility manager] saw the consumers tablet which was supposed to be kept in the staff closet as she can only have it at scheduled times. [Facility manager] informed the consumer that the tablet had been locked up for safety reasons of not being stolen or broken by other consumers and that it was not her scheduled time to have it. The consumer became irate threatening [facility manager] that she would beat her up if she did not return the tablet or that she would 'tear the m**********g house up'. The consumer then began knocking holes in the wall. As [facility manager] asked the consumer to stop she did not and continued to do further damage. [Facility Manager] stood in front of the consumer to prevent her from continue kicking the walls. At this time the consumer attempted to kick [facility manager] and eventually swung at [facility manager] striking her. [Facility manager] then implemented an EBPI (Evidenced Based Protective Interventions) approved hold but the consumer continued her attack and grabbed [facility manager] by her hair	V 110	Please see attached	

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V 110	Continued From page 5 and began pulling it tight trying to pull her hair out. As [facility manager] was able to get the consumer seated she refused to let go of [facility manager]'s hair and [facility manager] had to eventually get some scissors and cut her hair out to release the hold of her hair by the consumer. The consumer continued to cures and threaten for about 30-45 minutes before eventually calming down." Interview on 4-29-19 with the facility manager revealed: -She and staff #3 had been working the day of the incident on 4-20-19. -Client #2 had a court order visit with her mother and she had to be there at 10:00 am. -Facility manager told everyone to get up and get ready to leave for the visit. -All the clients had to go so the facility would be in ratio for staffing. -Client #3 did not want to get up. -Client #3 told her; "f**k you, b***h, I'm not getting up." -Client #3 continued cursing. -The facility manager took client #3's tablet and told her when she started behaving she could have it back. -Client #3 was only supposed to have her tablet if she was displaying good behavior. -Clients #2 and #4 were in the front room with staff #3 waiting for client #3 to get ready to go with them. -Client #3 was telling staff call her social worker, still cursing, the facility manager did try to call the social worker, but the call went to voicemail. -Client #3 threw the phone and hit staff #3. -Client #2 became angry because the phone hit staff #3. -"They both got so mad" (Clients #2 and #3)	V 110	Please see attached	

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V 110	Continued From page 6 -Both staff had to separate clients #2 and #3. -By this time it was 9:30 and she (facility manager) didn't want to put client #3 and client #2 in the same car to take client #2 to her visit. -Staff #3 didn't want to stay at the facility alone with client #3 because she was afraid of her. -The facility manager told staff #3 to take client #2 to her appointment. -Staff #3 left the facility with client #2.., leaving the facility manager at the facility with client #3 and #4. -Client #3 threatened to destroy the facility, saying she wanted to call her dad and that her dad would, "whip [facility manager]'s butt." -Client #3 slapped a cup of water down and pulled a cabinet door off the hinges. -Facility Manager prompted client #3 to stop and told client #4 to leave the area. -Client #3 kicked the wall, facility manager moved herself in between client #3 and the wall, facing client #3. -Client #3 grabbed both sides of facility manager's hair, facility manager grabbed client #3's hands to try to get client #3 to the release the hold she had on her. -Client #3 would not release her. -Facility manager told client #4 to go to the office desk drawer and pull out the scissors to cut her hair to get her free from client #3's grip. -"It was all I could think of to do." -Client #4 got the scissors and cut facility manager's hair loose from client #3's grip. -Client #3 was still trying to attack me. "I put her to the ground, I could only defend myself." -Facility manager stated she was kneeling beside client #3, who was on her back. -Client #3 was agitated for about 1 1/2 hours, with the actual physical altercation lasting about 7 minutes.	V 110	Please see attached	

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V 110	Continued From page 7 Observation on 4-29-19 at approximately 1100 am: -Large bald spots on the facility manager's head (top and sides) where client #3 had torn out her hair by the roots. -A bag containing cut hair. -Also several braids that the facility manager stated had been pulled out by the roots. Interview on 4-26-19 with staff #3 revealed: -The morning of the incident, client #3 did not want to get up, when she did get up, she was on her laptop. -The facility manager took her laptop. -"[Client #3] says; 'You give me my s**t', and began banging the walls." -"She threw the phone at me." -Client #2 had a court ordered visit. -"I left at 9:30, [facility manager] told me to go." -"[Facility Manager] thought she could handle it." -"When I left, [client #3] was walking an cussing." -"When I got back, I saw the house." (How it had been torn up by client #3) Interview on 4-23-19 with client #3 revealed; -She had been in her room asleep and the facility manager kept coming in and asking her to take her meds. -"I held my hand out, but she walked away." -The facility manager took her tablet from her. -I said; "Give me back my s***." -She slung a bottle of water off the table. -There were only three clients there that morning, herself, client #4 and client#2. -Staff #3 left the facility with client #2 to take	V 110	please see attached 	

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V 110	Continued From page 8 client #2 to her appointment. -She kept asking to call her social worker or her dad, but the facility manager said "no". -" I said, 'let me call my social worker or my dad or I am going to tear this place up.'" -She wanted someone to come pick her up from the facility. -Client #3 did attempted to call her social worker, but did not want to leave a message. -Client #3 did get in contact with her father. -She kicked a hole in the wall. -"[Facility manager] grabbed me by the back of my arm and slung me down." -Client #3 had large bruise on the back of her arm but said she might have hit a chair on the way down to the floor, she was not sure how she got the bruise. -Client #3 got hold of facility manager's hair, and facility manager had her by the hair also. -"She had me by my hair, I had her by her hair." -The facility manager was on top of her. -They finally let go of each other. -The facility manager had a long weave in, client #4 and the facility manager cut it. -Client #3 stated that the facility manager and client #4 cut the facility manager's hair after the altercation. -Client #3 took cutting the hair as a sign the facility manager was getting ready to fight her. -Client #3 kept asking to call her social worker or her dad. -She finally called her dad and he called her social worker's assistant. -She went to her room. Observation on 4-23-19 at approximately 11:09 of client #3 revealed; -bruise on the back of left arm, green, yellow, approximately 10 inches long.	V 110	please see attached 	

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V 110	Continued From page 9 -Scratch on right inner forearm. -Light bruise on index finger between middle and back knuckle. Interview on 4-23-19 with client #4 revealed: -The morning of 4-20-19, the facility manager kept asking client #3 to take her meds, giving her several prompts. -"[Facility Manager] took [client #3]'s tablet and [client #3] asked for it back." -Client #3 wanted to call her social worker and her dad. -Client #3 threw the phone at staff #3. -Client #2 got upset. -The facility manager decided client #2 had to go to her appointment before there was a fight. -"[facility manager] told [staff #3] to take her (client #2), and they drove off." -Client #3 kicked a hole in the wall. -"I saw them on the ground." -"[client #3] was pulling [facility manager]'s hair and wouldn't let go." -Client #4 cut the facility manager's hair to get her loose. -"[Staff #3] was gone for the whole incident. Interview on 4-25-19 with client #2 revealed: -She had a court ordered visit the day of the incident. -Client #3 was upset, she was trying to fight me." -"She (client #3) threw the phone at [staff #3]. I said, why you throw the phone at her, she didn't do anything." -"I told her to chill out." -"[Client #3] said, 'I'll fight you too.'" -"[Facility Manager] told me to get in the car and don't mess with her." Finding 2.	V 110	please see attached 	

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V 110	Continued From page 10 Review on 4-24-19 of IRIS (Incident Response Improvement System) dated 4-5-19 for incident on 4-3-19 revealed: -" When she (FC#5) was woken up to prepare for school that morning the consumer was verbally aggressive with [staff #1] and [staff #2] refusing to prepare for and go to school. Once [staff #2] escorted the other consumer of the home to the bus stop and [staff #1] was putting away the medications and securing the consumer charts, the consumer (FC#5) stole the van keys ran outside jumped in the facility vehicle before [staff #1] could stop her. [Staff #1] watched the consumer speed off and called [Director of Operations] before calling the police. A stolen vehicle and missing persons report was filed. The vehicle was located about 3 miles from the facility on the side of the road but the consumer was not located." Interview on 4-23-19 with staff #1 revealed: -"I heard a loud sound, Like a car, I looked outside, the car was gone." -"I don't know how she got the keys but it was not on my shift." -She had noticed that the van key was not on the key ring, but since she doesn't drive, sometimes other staff will take the key off the ring to use it. Interview on 4-25-19 with FC#5 revealed: -There is a closet in the kitchen containing toilet paper, cleaning supplies, etc. -She asked staff for the keys to get something out of the closet.,"I asked for the keys, I won't say who, they handed me the keys." -"Any of the staff would give you the keys	V 110	Please see attached	

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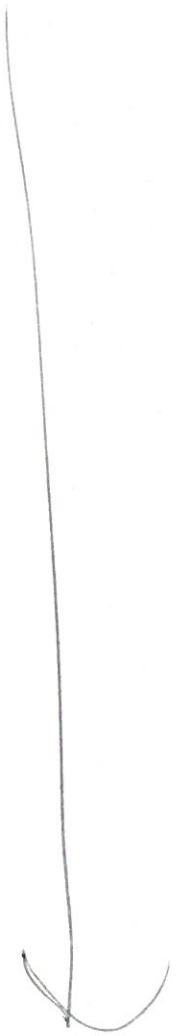
V 110	Continued From page 11 regularly." -"I took the car key off and left the yellow thing on, and put the key in my pocket." -"I slipped out the window in the bedroom." -"I do what I do." -She had previously stolen several cars and that is why she was on probation. -At her first treatment team meeting everyone was told to keep the keys locked up. -"I got in the van and left. I rolled the window down because I couldn't see because of the frost." -She didn't know the exact time. She looked back but didn't see any staff. Interview on 4-23-19 with client #1 revealed: -Client #3 came back to the facility in the evening, and the next morning she stole the van. -"[Client #3] asked [staff #4] for the keys to get Band-Aid from the closet." -[Staff #4] gave her the keys." -Any staff except the facility manager would regularly give the clients the keys to the closet. -At that time, FC#5 took the car key off the ring and gave the rest of the keys back to staff #4. -She thinks staff #1 was working with staff #4 that evening. -The next day FC#5 stayed back with staff #1. "[Client #2] was going to go (with FC#5), but she went to school." -FC#5 threw all her clothes out the window then climbed out. -"She cranked up the car. [Staff #1] had to call the cops." Interview on 4-29-19 with staff #4 revealed: -The staff usually keep the keys locked up, but that day one of the other consumers had accidentally hit staff #1 with her cane, so there	V 110	please see attached 	

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V 110	Continued From page 12 was some confusion in the house. -The staff was trying to transition shifts, and deal with the incident. -"I think that's when she (FC#5) could have gotten them (the keys)." -"I believe she could have easily come by the desk real quick." -"there are so many keys on there (key ring), we didn't notice." -The clients are not allowed to get things from the closet themselves, staff have to do that. This deficiency is crossed referenced into 10 A NCAC 27G .1701 Scope (V293) and must be corrected within 23 days.	V 110	Please see attached	
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 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:	V 293		

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TURN AROUND	9709 BATTEN COURT MINT HILL, NC 28227

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V 293	Continued From page 13 (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. This Rule is not met as evidenced by: Based on record reviews, interviews and observation the facility failed to ensure that services were designed to minimize the occurrences of behaviors related to functional deficits, and ensure safety and de-escalate out of control behaviors. effecting 3 of 4 current clients (clients #2, #3, and #4) and 1 of 1 former client	V 293	Please see Attached	

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V 293	Continued From page 14 (Former client #5). The findings are: Crossed referenced 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110). Based on interviews and record review, that 3 of 4 staff (staff #1, #4 and the facility manager) failed to show competency. The findings are: Cross reference 10A NCAC 27G .1704 Minimum Staffing Requirements (V296). Based on record reviews and interviews the facility failed to ensure the minimum number of direct care staff required when clients were in the facility. The findings are: Interview on 4-29-19 with the licensee in response to the citations revealed: -They have two staff scheduled, but staff does take the clients to the bus stop. On 4-23-19 she thought the facility manager was there to help cover and was not aware she had not gotten there yet. She thinks Former client #5 got the keys to the van when there was a window of opportunity because another client had accidentally hit staff with the staff's cane and there was a lot going on at that time. When clients #2 and #3 briefly ran away from the facility, there was one staff present only because staff #4 had a family emergency and had to leave early. The facility manager made the decision to send staff #3 with client #2 so client #2 could attend her family visit and client #2 needed to be removed so she wouldn't fight with client #3. The facility made the decision to ensure client safety. The van keys should be secured at all times. All staff knew about client #3's history of car theft. Client #3 used a small window of opportunity and took the keys. The licensee did not think that staff would hand the keys to the clients under any	V 293	please see attached	

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V 293	Continued From page 15 circumstances. The staff have been keeping the van key separate from the other group of keys and keep it locked up in the med closet. Administration has processed with the facility manager about keeping scissors locked up and away from clients. "It sounds bad and there is no justifications." Review on 4-30-19 of Plan of Protection dated 4-30-19 and signed by the Director of Operations revealed: What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? "New Place Inc will utilize all administrative staff immediately (4-30-19) to ensure that two staff are on duty and remain in the home at all times with one or more consumers. The clinical Director [Clinical Director] will cover [facility] between the hours of 6a-8a to ensure that two staff remain in the home when consumers are being monitored at the bus stop. The Director of Operations [Director of operations] will cover any and all gaps between 2p-5p when consumers are being monitored off the school bus or suspended from school. The director of Operations will ensure that if any appointments are scheduled, in which any consumers refuse to go to the appointment, the appointment will be canceled or rescheduled. The Director of Operations [Director of Operations] has ensured that all sharp objects such as scissors that could cause potential harm are removed immediately from the staff office. Director of Operations [director of operations] will ensure that any client that displays aggressive behavior against staff or other client in the home within a 30 day time frame will be discharged for health and safety purposes. Each staff at the	V 293	Please see attached	

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V 293	Continued From page 16 facility will receive a training that will cover the crisis plan." Describe your plans to make sure the above happens. "Director of Operations [director of operations] and Clinical Director [clinical director] will ensure that the above measures happen in order to bring the facility back in compliance. The crisis plan trainings will be conducted immediately with each staff at the facility by the QP (Qualified Professional), [QP], CD (Clinical Director)-[CD], or DOO (Director of Operations)[DOO]." Former client #5 had a history of stealing automobiles and client #3 had a history of aggressive behaviors. On 4-2-19, former client #5 had the opportunity to slip out of her bedroom window and steal the facility van when there was only one staff (staff #1) present with two clients (Former client #5 and client #1). Former client #5 obtained the keys to the van the night before when staff either handed them to her or failed to secure them. On 4-20-19, client #3 attacked the facility manager after the facility manager made the decision to send staff #3 away from the facility, leaving her alone with client #3 and client #4. On 4-22-19, client #3 and client #4 went AWOL after staff #4 left her shift early, leaving only one staff (staff#1) at the facility. This deficiency was cited as a Type A2 violation during the survey completed 3-4-19, but evidence in this survey has increased the severity of this deficiency. This deficiency constitutes a type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of 2,000.00 is imposed. If the violation is not corrected within 23 days, an additional penalty of 500.00 per day will be imposed for each day	V 293	please see attached 	

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V 293	Continued From page 17 the facility is out of compliance beyond the 23 day	V 293	please see attached	
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's	V 296		

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V 296	Continued From page 18 individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on record reviews, observation, and interviews the facility failed to ensure the minimum number of direct care staff required when clients were in the facility effecting four of four current clients and one of one former client (clients #1 #2, #3, #4, and former client #5). The findings are: Review on 4-24-19 of client #3's record revealed: -Admitted 4-9-19 -15 years old. -Diagnosis of Major Depressive Disorder-Single episode. -Admission assessment dated 4-9-19 revealed: Lateral move, verbal aggression, self-injurious behavior, steals... -Diagnostic Assessment Addendum dated 5-21-18 revealed; continues to be aggressive...was recently hospitalized due to aggressive and self injurious behavior..." -Person Centered Plan dated 4-4-19 revealed; "continues to lash out at peers and staff...attempted to run away from group home 3 times in 30 days...jumped out of the window of the group home to fight another client..."	V 296	please see attached	

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V 296	Continued From page 19 Review on 4-24-19 of former client #5's (FC#5) record revealed: -Admitted 11-13-18. -15 years old. -Diagnoses of Unspecified Impulse Control Disorder, Conduct Disorder, Unspecified Trauma and Stressor Related Disorder, and Moderate Cannabis Use Disorder. -Clinical Diagnostic Assessment dated 3-27-18 revealed: "Ran 3 times from foster homes...she and a friend took a car without permission and ran into a tree stump...history of substance abuse and running away...." -Admission Assessment dated 11-13-18 revealed; "Level II foster placement recently disrupted due to elopement behavior as well as risky and unsafe behavior...currently on probation due to driving without a license and unlawful use of a motor vehicle ." -Person Centered Plan last updated 3-11-19 revealed: currently in detention for stealing another vehicle...goals include; will comply with current conditions of probation...will participate in therapy positively as evidenced by attending scheduled therapy and addressing issues with DSS (department of social services) custody...will attend school daily...staff will monitor, help with coping skills, transport to therapy. Finding #1: Observation on 4-23-19 at approximately 6:30 am revealed: -One car in the facility's driveway. -One staff (Staff #1) at the facility, along with one client (client #1) was observed. -Approximately 6:56 am staff #1 received phone call on her cell phone and asked person	V 296	Please see attached 	

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V 296	Continued From page 20 on the other end "You're on your way?, OK." -7:05 am car pulling into the driveway, facility manager came into facility. Interview on 4-23-19 with staff #1 revealed: -She was the only staff at the facility. -She said that there were 3 clients in the facility but did not say who they were. -Staff #2 had taken some of the clients to the bus stop. -Someone did this every school day. Interview on 4-25-19 with staff #2 revealed: -He takes client #2, #4 and he used to take former client #5 (FC#5) to the bus stop near another facility every morning that there is school. -He is gone about 20 minutes. -He then goes back to make sure all the work is done at the facility. Finding #2 revealed: Review on 4-24-19 of IRIS (Incident Response Improvement System) dated 4-5-19 for incident on 4-3-19 revealed: -"After the consumer (FC#5) was returned to the facility on 4-2-19 after she went AWOL (absent without leave) from her home during a home visit she was already non-compliant. When she was woken up to prepare for school that morning the consumer was verbally aggressive with [staff #1] and [staff #2] refusing to prepare for and go to school. Once [staff #2] escorted the other consumer of the home to the bus stop and [staff #1] was putting away the medications and securing the consumer charts, the consumer (FC#5) stole the van keys ran outside jumped in the facility vehicle before [staff #1] could stop her. [Staff #1] watched the consumer speed off and called [Director of Operations] before calling the	V 296	Please see attached 	

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V 296	Continued From page 21 police. A stolen vehicle and missing persons report was filed. The vehicle was located about 3 miles from the facility on the side of the road but the consumer was not located." Interview on 4-23-19 with staff #1 revealed: -She was working the day FC#5 took the van. -Staff #2 had taken the other clients to the bus stop. -"I was working that morning, I told her to get ready." -"I heard a loud sound, like a car, I looked outside, the car was gone. -"I don't know how she got the keys but it was not on my shift." -She had noticed that the van key was not on the key ring, but since she doesn't drive, sometimes other staff will take the key off the ring to use it. Interview on 4-25-19 with staff #2 revealed: -He had been working that morning and he took clients #2 and #4 to the bus stop. -FC#5 refused to go to school that day. -"When I left, [FC#5] was still in bed and staff #1 and client #1 were there." -When he got back the police were there. -He was only gone about 15 minutes. -He took his personal car to transport the clients. -The van keys were on a key ring that staff keeps in their possession. Interview on 4-23-19 with client #1 revealed: -Staff #1 had stayed back with FC#5. -[FC#5] threw all her stuff out the window, she climbed out the window, she cranked up the car, [staff #1] had to call the cops." Interview on 4-25-19 with FC#5 revealed:	V 296	Please see attached	

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V 296	Continued From page 22 -She went AWOL from a home visit and DSS took her back to the group home. -She didn't have her ankle monitor on because she had taken off during her AWOL. -The next morning she refused to go to school because she was "sleeping off some stuff." -She eventually got up and got dressed. -The other girls had gone to school. She didn't know if client #1 was there or not. -Staff #1 was working by herself. -"I slipped out the window in the bedroom." -"I do what I do." -She had previously stolen several cars and that is why she was on probation. -"I got in the van and left. I rolled the window down because I couldn't see because of the frost." -She didn't know the exact time that she left. She looked back but didn't see any staff. Interview on 4-25-19 with the Department of Juvenile Justice worker for FC#5 revealed: -FC#5 had a long history of stealing cars, "at least 6." -"She is manipulative and very dishonest." -FC#5 told him that she had asked for the keys the previous night and taken the van key off the ring when staff gave her the keys. -FC#5 would not say what staff gave her the keys. Finding #3: Review on 4-24-19 of IRIS report dated 4-22-19 of incident occurring 4-20-19 revealed: -"Around 8:45 an the consumer (client #3) was woke up by [facility manager] to address her morning hygiene and to clean her area as they had to take another consumer on a day visit to	V 296	Please see attached	

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V 296	Continued From page 23 DSS (Department of Social Services) . The consumer refused to get out of bed but eventually went to the bathroom her peer asked her if she could get ready because she did not want to be late to her visit and consumer began to threaten her peer stating she did not care about her visit. This led to an argument which required staff intervention to prevent further altercation." Interview on 4-23-19 with client #3 revealed: -There was an incident the previous weekend. -The facility manager took her tablet and then refused to let her call her social worker of her father. -They got into a physical altercation. -The facility manager was the only staff in the facility at the time. Interview on 4-26-19 with staff #3 revealed: -She is a floater and works at all the homes. -She got to the facility at approximately 8:00. -Client #3 did not want to get up. -"When she got up, she was on her laptop." -"The supervisor (facility manager) wanted to take the laptop and [client #3] says 'you give me my s**t'." -Client #3 began banging the walls. -"She threw the phone at me, she was cussing me and my grandmother." -"I left around 9:30." (To take client #2 to her DSS visit) Interview on 4-23-19 with client #4 revealed: -Sometimes on the weekend, staff work by themselves. -The morning of 4-23-19 staff #2 had taken her to the bus stop. Client #2 had been suspended so it was just her. -Staff #2 gets off from work after he takes her	V 296	please see attached	

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V 296	Continued From page 24 to the bus stop and she gets on the bus. -The morning of 4-20-19 the facility manager told staff #3 to take client #2 to her appointment and leave the facility manager there by herself. Interview on 4-29-19 with the facility manager revealed: -She and staff #3 were at the facility the day of the incident on 4-20-19. -Client #2 had a court ordered family visit at 10:00. -Client #3 at first refused to get up, then got up cursing at staff. -Client #2 and #3 were arguing with each other because client #3 threw the phone and hit staff #3. -She decided that she couldn't put the two clients in the same vehicle so she sent staff #3 with client #2 to client #2's visit. -Client #3 was aggressive and attacked her, pulling out her hair. Finding #4: Interview on 4-23-19 with client #1 revealed: -Last night (4-22-19) staff #1 was working by herself and clients #2 and #3 ran away from the facility. -It was dark at the time. -Earlier in the day, they had gone by staff #4's house to visit her son, who had been injured. They also picked up staff #1 and brought her to the facility for her shift. -Staff #4 had gotten off early. -Client #2 had a cell phone and client #3 called someone to come get them. -They both went out client #2's window. -Staff #1 was sitting in the staff area. -Client #4 told staff #1 that the girls had left. -Staff #2 pulled in and was told to go find the	V 296	please see attached	

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V 296	Continued From page 25 girls. -Staff #2 did find the girls and brought them back without further incidents Interview on 4-23-19 with client #2 revealed: -She and client #2 had gone AWOL the previous night. -Staff #1 was the only staff in the facility at the time. -Staff #2 had not gotten there yet. -Staff #3 had left early to go see her son at the hospital. -Staff #2 found them at the store and brought them back to the facility. Interview on 4-23-19 with staff #1 revealed: -She was working by herself for a very short time the night before. -Clients #2 and #3 went out the window. -They were not gone very long, she called staff #2 and he found them at a local store and brought them with him when he came on shift. -There were no problems resulting from the AWOL. Interview on 4-29-19 with staff #3 revealed: -She was not there when clients #2 and #3 went AWOL. -Her son had been injured that day and she had to go to the emergency room. -"I think I left maybe 15 minutes early." -"[Staff #1] and [Staff #2] were there." This deficiency is crossed referenced into 10 A NCAC 27G .1701 Scope (V293) and must be corrected within 23 days.	V 296	Please see Attached	

Turnaround MHL-060-648

Plan of Correction for Complaint Survey completed 12/28/2018

V110 27G .0204 Training/Supervision Paraprofessionals
10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS

This Rule is not met as evidenced by: Based on interviews and record review, 3 out of 4 staff (staff #1, #4 and the facility manager) failed to demonstrate knowledge, skills and abilities required by the population served.

On 06/13/2019 Executive Director James Hunt held a mandatory monthly staffing/supervision to include training. During this group supervision/training the following topics will be covered: Scope, Competencies and Supervision of Paraprofessionals, Medication Requirements, Facility and Grounds Maintenance Location and Exterior Requirements. This training will focus on the technical knowledge, cultural awareness, analytical skills, decision making, communication skills and clinical skills. This training will also cover implementation of Person-Centered Plan Goals, and Incident reporting. Ongoing monitoring of this goal will be conducted by Clinical Director Artemus Flagg via monthly supervision.

V293 27G .1701 Residential Tx. Child/Adol - Scope

This Rule is not met as evidenced by: Based on records review and interviews, and observation the facility failed to ensure that services were designated to minimize the occurrences of behaviors related to functional deficits, and ensure safety and de-escalate out of control behaviors, effecting 3 of 4 currentclients (clients #2, #3, and # 4) and 1of1 former client (former client #5.

On 06/13/2019 Executive Director James Hunt held a monthly group supervision/training to have a refresher covering scope to include review of supervision to ensure safety, person centered plans, comprehensive crisis plans, incident reports, de-escalation techniques, and better decision making for the population served amongst other topics. Each employee will continue to have monthly supervision to revisit each of these topics individually or as a whole if the need arises. The monthly supervision will be conducted by Executive Director James Hunt and/or Clinical Director Artemus Flagg. The monitoring of this will be ongoing and will be reviewed quarterly by the Quality Assurance and Quality Improvement Committee based on reviews of incident reports, staff performance, and any reported allegations or consumer complaints.

V296 27G .1704 Residential Tx. Child/Adol - Min. Staffing
10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS

This Rule is not met as evidenced by: Based on Records review, observation and interviews, the facility failed to ensure the minimum of direct care staff required when clients were in he facility effecting four of four current clients and one of four former clients (clients # 1, #2, #3, #4 and former client #5).

As of 06/07/2019 Executive Director James Hunt met with Director of Operations Hawa Hunt to assure that each schedule created will meet minimum staffing requirements on each shift each day. As of 06/10/2019 Executive Director James Hunt circulated a memo for Turnaround facility requiring each

staff member to work their entire shift and if they have to leave it shall be for an emergency only and they must contact Director of Operation Hawa Hunt for approval to leave early and that staff member must remain at the facility until a designated relief staff arrives. The monitoring of this will be ongoing as random unannounced visits to the facility will be made by administration (Executive Director, Director of Operations, and/or Clinical Director) to assure that scheduled staff are present.

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

June 10, 2019

Mr. James Hunt, Executive Director
New Place, Inc.
6612 E. Harris Blvd
Charlotte, NC 28215

Re: Follow up Survey completed 5-2-19
Turn Around, 9709 Batten Court, Mint Hill, NC 28227
MHL # 060-648
E-mail Address: hawa1908@aol.com

Dear Mr. Hunt:

Thank you for the cooperation and courtesy extended during the follow up survey completed 5-2-19.

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

Type of Deficiencies Found

- Type A1 rule violation is cited for 10A NCAC 27G .1701 Scope (V293) with cross references from; 10A NCAC 27G .0205 Competencies and Supervision of Paraprofessionals (V110) and 10A NCAC 27G .1704 Minimum Staffing Requirements (V296).

Time Frames for Compliance

- Type A1 violations and all cross referenced citations must be ***corrected*** within 23 days from the exit date of the survey, which is 5-24-19. Pursuant to North Carolina General Statute § 122C-24.1, failure to correct the enclosed Type A1 violation by the 23rd day from the date of the survey may result in the assessment of an administrative penalty of $500.00 (Five Hundred) against New Place, Inc. for each day the deficiency remains out of compliance.

What to include in the Plan of Correction

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

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

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

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

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Lynn Grier at 704-596-4072.

Sincerely,

Patricia Work

Patricia Work
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: DHSRreports@dhhs.nc.gov, DMH/DD/SAS
qmemail@cardinalinnovations.org
QM@partnersbhm.org
dhhs@vayahealth.com
Pam Pridgen, Administrative Assistant