STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-807	A. BUILDING: _____ B. WING _____	C 07/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER OF PROGRESSIVE STRIDES	2212 GLENSIDE DRIVE GREENSBORO, NC 27405

(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 complaint survey was completed on July 31, 2019. Two of the complaints were substantiated (intake #NC00151971 and intake #NC00152061) and one was unsubstantiated (intake #NC00151960). 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; (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.	V 109		

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V 109	Continued From page 1 (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 observations, interviews and record reviews, 2 of 2 qualified professionals (the Licensee #1 and Qualified Professional (QP)) failed to demonstrate the knowledge skills and abilities required by the population served. The findings are: Review on 7/16/19 of the Licensee #1's record revealed: - Hire Date: 1/19/07 - Position: Co-Owner/President - Based on review of the record, the Licensee #1 had a degree and work history that qualifies him as a Qualified Professional. Review on 6/7/19 of the Qualified Professional's (QP) record revealed: - Hire Date: 12/28/17 - Position: QP - Based on review of the record, the QP had a degree and work history that qualifies her as a QP. - She was no longer employed by Center of Progressive Strides, Inc. at exit the date of 7/31/19.	V 109		

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V 109	Continued From page 2 Finding #1 Interview on 6/11/19 with the Licensee #1 revealed: - When client #2 reported to him on 5/20/19 that on 2 occasions (5/17/19 and 5/19/19) former staff (FS #11) sexually abused him, the Licensee #1 chose to not focus on the 5/17/19 incident. - Prior to a forensic interview being completed as well as investigations being completed by law enforcement or child protective services he determined that client #2 had not been sexually abused and no criminal act had occurred in his group home. - "[Client #2] told me that same night (early morning of 5/20/19) he briefly mentioned that [FS #11] touched him in the car. I didn't really focus in on that. I focused on the conversation about him being made to suck his (FS #11's) penis." - "I turned it over to [the Licensee #2] and [the QP] to handle. They (Licensee #2 and the QP) talked to the mother (client #2's mother) extensively. The mother (client #2's mother) signed a document that she didn't think anything happened." - "I don't think this incident happened at all and nothing occurred criminally." Interview on 7/29/19 with client #2 revealed: - When he disclosed to the Licensee #1 he was sexually abused by FS #11, the Licensee #1 searched his room for a cell phone that had a recording client #2 had made of FS #11 stating "whip it out so I can suck it." - The recording was not clear because it recorded the television playing in the background. After listening to the recording, the Licensee #1 said that he could not hear anything, and he did not believe him (client #2). - "I eventually had to give [the Licensee #1] my	V 109		

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V 109	Continued From page 3 (cell) phone." - "He searched my room, he threw my clothes on the floor and turned my mattress over." - "I showed him (Licensee #1) the voice recording, and he said I can't hear anything. I told him (Licensee #1) to be quiet and listen to it. [The Licensee #1] said he didn't believe me. [The Licensee #1] said he would put my (client #2's) cell phone in the glove box (in the Licensee #1's car) ..." - He ran away from the group home after his forensic interview (6/24/19) because "they (Licensee #1 and Licensee #1) kept trying to get me to drop the charges." - The Licensee #1 told him on two occasions to drop the charges after the forensic. - He was aware the Licensee #1 was a "police chief" (assistant). - "[The Licensee #1] said [FS #11] did not do this so you might as well drop the charges." - "We (client #2, Licensee #1 and Licensee #2) were on the cement in front of the porch (at the group home). They (Licensee #1 and Licensee #2) both said 'they (police) don't believe you downtown (at the police department) so you might as well drop it.' I said to [Licensee #2] and [Licensee #1] he (FS #11) did it and I am not going to drop it. " Interview on 6/24/19 with client #2's mother revealed: - After being contacted by her son (client #2) on 5/20/19 at approximately 12:04 am and told a staff member sexually abused her son, she contacted the QP and then the Licensee #1. - "He (client #2) told me that I needed to get up there because one of the staff was trying to make him suck his penis and I said I would call him back." - She contacted the QP.	V 109		

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V 109	Continued From page 4 - "I told [the QP] I was about to call the police and she said let me call [the Licensee #1] first. She said [the Licensee #1] will call you." - "[The Licensee #1] called me back and I told him I was about to call the police to your (his) group home and he (the Licensee #1) said you can call the police but please don't because I am headed right over there." Review on 6/6/19 of Incident Reports revealed: - No documentation of search and seizure of client #2's cell phone. Finding #2 Interview on 6/7/19 and 6/18/19 with the QP revealed: - She learned on 5/20/19 at approximately 12:27 am about allegations that former staff (FS #11) had sexually abused client #2 on two different occasions 5/17/19 and 5/19/19. - She did not report this to child protective services or law enforcement. - After learning about client #2 allegedly being sexually abused she, the Licensee #2 held a meeting with client #2 and client #2's mother for 7 hours to discuss the allegations. - "We, myself, [client #2's mother], [the Licensee #2] and [client #2] were here (group home) from 8 am until 3 pm on the 20th (5/20/19) discussing what happened in detail. After we all talked that's when the mother signed a statement." - She had client #2's mother to sign a statement which indicated she did not believe the allegations. Review on 6/7/19 of the statement by client #2's mother dated 5/20/19 revealed: - The statement by client #2's mother was written by the QP and signed by client #2's mother and	V 109		

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V 109	Continued From page 5	V 109		

the QP.
- "[Client #2's mother] has been aware of the allegations that have been made by her son regarding a sexual act that supposedly to place with a staff member [FS #11] in COPS group home. [Client #2's mother] has stated that she does not believe that the allegations are true but does believe that further investigation should take place by COPS (Center of Progressive Strides) group home management. [Client #2's mother] stated that she did not want to call the police as she feels that the Management team of COPS is adequate to handle the situation. We will be documenting the incident and determine if [FS #11] will continue is employment with COPS, but until further noticed he is suspended. COPS management team believes that there was no criminal act that took place but will still further investigate."

Interview on 7/1/19 with client #2's mother revealed:
- She never signed a statement indicating she did not believe that her son (client #2) was sexually abused by FS #11.
- " ...I signed a statement saying it needed to be investigated. I told them DSS (the Department of Social Services) needed to be called. (I told them) I think this man (FS #11) had inappropriate conversation with [client #2] and questioned if other things occurred."

Observation on 6/24/19 at approximately 2:00 pm of client #2's forensic interview revealed:
- There was a meeting with client #2, his mother, the Licensee #2 and the QP the following morning (5/20/19) after he disclosed FS #11 sexually abused him.
- During the meeting a recording of what FS #11 stated the night before (5/19/19) to client #2 was

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V 109	Continued From page 6 played but it was difficult to understand due to a television was playing in the background. - After the recording was played in the meeting at approximately 2:34 pm "we (the Licensee #2 and QP) still don't believe you." - At approximately 2:35 pm client #2 stated, "[The QP] started treating me differently (after he disclosed the sex abuse by FS #11). (The QP said) why did you snitch on [FS #11]." - He had his cell phone with him during the forensic, but the recording was not played in the forensic. - He provided his cell phone to the detective at the end of the forensic interview. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	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	V 110		

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V 110	Continued From page 7 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. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, 1 of 4 current paraprofessional staff (the Licensee #2) and 1 of 1 former paraprofessional staff (former staff (FS #11)) failed to demonstrate the knowledge skills and abilities required by the population served. The findings are: Review on 7/16/19 of the Licensee #2 record revealed: - Hire Date: 10/1/07 - Position: Co-Owner/Vice-President -Based on review of the record, the Licensee #2 has education and work history that qualifies him as a Para-professional. Review on 6/7/19 of FS #11's record revealed: - Hire Date: 6/1/19 - Paraprofessional - On 5/1/18 sex offender search was "complete clear"	V 110		

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V 110	Continued From page 8 - Currently has a revoked license and disposition date is 8/2/19. Finding #1 Observation on 6/24/19 at approximately 2:00 pm of client #2's forensic interview revealed: - There was a meeting with client #2, his mother, the Licensee #2 and the Qualified Professional the following morning (5/20/19) after he disclosed FS #11 sexually abused him. - During the meeting a recording of what FS #11 stated was played but it was difficult to understand due to a television was playing in the background. - At approximately 2:33 pm client #2 said, "[The Licensee #2] said, 'I still don't believe you.' " - He had his cell phone with him during the forensic, but the recording was not played in the forensic. - Client #2 provided his cell phone to the detective at the end of the forensic interview. Review of "Investigative Summary Regarding [Client #2]" dated 7/21/19: - Signed by the Licensee #2 on 7/21/19 but as the "President-Co-Owner." - "Shortly after 10 am (on 5/20/19), I (Licensee #2), [the Qualified Professional], [client #2's mother], and [client #2] all were at the facility discussing the incident." - "At the conclusion of the conversation, [client #2's mother] signed a document that she felt there was no criminal act to have occurred and she wanted our staff to continue to address the issue." - "This incident is currently being investigated by Child Protective Services, [Sheriff Department], and [Police Department]." - "After careful review of the aforementioned	V 110		

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V 110	Continued From page 9 information I as the President (Vice-President) and Co-Owner of The Center of Progressive Strides, Inc. facility shall declared this investigation as Unfounded and this matter is closed." Interview on 7/29/19 with client #2 revealed: - He was aware that the Licensee #2 was a former policeman. - He ran away several times after he disclosed in his forensic interview that FS #11 sexually abused him. - He ran away because "they (Licensee #2 and Licensee #1) kept trying to get me to drop charges." - On 2 occasions after client #2's forensic interview, the Licensee #2 told him he should drop the charges against FS #11 who had allegedly sexually abused him. - "[The Licensee #2] is retired he was a policeman." - "We (client #2, Licensee #1 and Licensee #2) were on the cement in front of the porch (at the group home). They (Licensee #1 and Licensee #2) both said 'they (police) don't believe you downtown (at the police department) so you might as well drop it.' I said to [Licensee #2] and [Licensee #1] 'he (FS #11) did it and I am not going to drop it.' " - "You should just drop this (the charges against FS #11) I know you are tired of going through this. [The Licensee #2] said this when he drove me home for a home visit." Interview on 6/14/19 with the Licensee #2 revealed: - Staff #5 was the only staff who worked on 5/19/19 from 8 am- 5pm. - "That was my bad on that (to have one staff on shift). That was a weekend (5/18/19 and 5/19/19)	V 110		

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V 110	Continued From page 10 we were having staffing problems and I decided to wing it. That was my call on that." Interview on 6/11/19 with the Licensee #1 revealed: - The Licensee #2 scheduled staff. - "[Licensee #2] was in charge of taking care of the shift and [Licensee #2] was to make sure that enough staff was there to cover." Review of "Investigative Summary Regarding [Client #2]" written by Licensee #2 dated 7/21/19: - During his internal investigation of client #2 allegedly being sexually abused by FS #11 he determined the allegations to be "unfounded" while the law enforcement and child protective services investigations were still ongoing. - "This incident is currently being investigated by Child Protective Services, [Sheriff Department], and [Police Department]." - "After careful review of the aforementioned information I as the President (Vice-President) and Co-Owner of The Center of Progressive Strides, Inc. facility shall declared this investigation as Unfounded and this matter is closed." Interview on 7/24/19 with former staff (FS #11) revealed: - His driver's license had been revoked for "about 3 years" but he had never told anyone at the group home his driver's license was revoked. Interview on 7/25/19 with the Qualified Professional #2 revealed: - The Licensee #2 did hire FS #11 and the Licensee #2 knew at the time FS #11 was hired that FS #11's license was revoked. - When FS #11 was first hired he was being dropped off and picked up for work.	V 110		

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V 110	Continued From page 11 - Sometime in April 2019 FS #11 showed proof of car insurance but the Licensee #2 never checked to see if FS #11's license was reinstated. Interview on 6/6/19 with the Licensee #2 revealed: - After the group home staff learned about FS #11 possibly sexually abusing client #2, the staff did not notify child protective services (CPS) or law enforcement. - "CPS came in on 5/20/19 prior to us calling because we were going to call them the next day after we got all of our statements together. They (CPS Social Worker) came in around 8 pm on 5/20/19." - "Once Child Protective Services (CPS) Social Worker came in he said they would make all notifications. We didn't call law enforcement because we knew CPS was going to make all notifications on 5/20/19." Review on 7/29/19 of police report dated 6/3/19 revealed: - The police report did not have a report of the allegations from the group home staff. - A report was received "from Guilford County DSS (Department of Social Services)." - The victim was listed as "[client #2]." - "On 5/28/19 this case was forwarded to Greensboro Police Department's Family Victims Unit in regards to Indecent Liberties of a child." Finding #2 Interview on 6/19/19 with FS #11 revealed: - He worked part of the shift on 5/19/19 by himself because staff #1 left. - Staff #1 left during his shift on 5/19/19 from approximately 9:45 pm-11:30 pm "because something happened at his mother's house. "	V 110		

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V 110	Continued From page 12 - He nor staff #1 reported to anyone that staff #1 left "because I figured he was coming right back. I told him if everything is not ok with your mom to handle that." - Client #2 disclosed to him on 5/19/19 that he was molested when he was younger. - He told client #1 he was molested as well. - "I explained that I was molested, and it did not make me less of a man." Interview on 7/24/19 with FS #11 revealed: - He did wrestle with client #2 one time but did not write up an incident report when this occurred. - "One time [client #2] grabbed me from the back. I tossed him over my shoulder, and he landed on the floor and he jumped up real fast and said, 'you can move for an old guy.' " Interview on 6/7/19 with staff #1 revealed: - He worked the shift with FS #11 on 5/19/19 but left early to take his wife to work. - He was gone from approximately 8 pm-9 pm. - He did not notify anyone he had left early. - "I had to leave and take my wife to work and that is when everything happened (the allegations FS #11 sexually abused client #2) and I am probably going to be in trouble for that. I shouldn't have left." This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 110		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY	V 132		

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	MHL041-807	A. BUILDING: _____ B. WING _____	C 07/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER OF PROGRESSIVE STRIDES	2212 GLENSIDE DRIVE GREENSBORO, NC 27405

(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 132	Continued From page 13 (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.	V 132		

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V 132	Continued From page 14 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report the results of an investigation within 5 working days of the initial notification to the Department. The findings are: Review on 6/5/19 of Incident Response Improvement System (IRIS) revealed: - There was an initial report submitted on 5/21/19 by the provider but an internal investigation had not been submitted. Interview on 6/10/19 with the Qualified Professional revealed: - She did not have the completed internal investigation report. - She was waiting on the Licensee #1 to "finish typing" the report. Review of "Investigative Summary Regarding [Client #2]" dated 7/21/19: - Signed by the Licensee #2 on 7/21/19 but as the "President-Co-Owner." This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 132		
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	V 293		

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V 293	Continued From page 15 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: (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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V 293	Continued From page 16	V 293		

This Rule is not met as evidenced by:
Based on observations, record review, and interview, the facility staff failed to ensure continuous staff supervision, structure, and safety in order to minimize the occurrence of behaviors related to functional deficits affecting 1 of 2 current clients (#2) and of 1 of 1 former client (FC #3). The findings are:

Cross reference: G.S. 131E -256 HCPR Prior Employment Verification (V132). Based on record reviews and interviews, the facility failed to report the results of an investigation within 5 working days of the initial notification to the Department.

Cross reference: 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109). Based on observations, record reviews, and interviews 2 of 2 qualified professionals (the Licensee #1 and Qualified Professional (QP)) failed to demonstrate the knowledge skills and abilities required by the population served.

Cross reference: 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110). Based on observations, interviews and record reviews, 1 of 4 current paraprofessional staff (the Licensee #2) and 1 of 1 former paraprofessional staff (former staff (FS #11)) failed to demonstrate the knowledge skills and abilities required by the

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V 293	Continued From page 17 population served. Cross reference: 10A NCAC 27G .1704 Minimum Staffing Requirements (V296). Based on record review and interviews, the facility failed to have two direct care staff present while the clients were awake or asleep affecting 2 of 2 current clients (#1 and #2) and of 1 of 1 former client (FC #3). Cross reference: 10A NCAC 27G .0603 Incident Response Requirements (V366). Based in interviews and record reviews, the facility failed to report a Level III incident to other authorities (Law Enforcement) required by law. Cross reference: 10A NCAC 27D .0101 Policy on Right Restrictions and Interventions (V500). Based on record review and interview, the facility failed to ensure all instances of allegations of abuse were reported to the County Department of Social Services (DSS) affecting 1 of 2 current clients (client #2). Review on 7/25/19 of the Plan of Protection dated 7/25/19 and written by the Qualified Professional #2 (QP #2) revealed: What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? Describe your plans to make sure the above happens. "10A NCAC 27G.0203 & 10A NCAC 27G.0204 - The Qualified Professional (#2) will in-service the owners, Associate Professionals, and paraprofessionals on the program structure; including all rules and regulations. This will be effective July 25, 2019.	V 293		

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V 293	Continued From page 18 10A NCAC 27G.1701 - The Qualified Professional (#2) will ensure that the residential facility (C.O.P.S) (Center of Progressive Strides) will provides intensive, active therapeutic treatment and interventions within a system of care approach. This will be effective July 25, 2019. 10A NCAC 27G.1704 the agency will follow all staffing requirements outlined in the NCDHHS (North Carolina Department of Health and Human Services) rules and regulations. The Qualified Professional (#2) will supervise the agency and ensure there will always be a minimum of 2 staff at all times effective July 25, 2019. 10A NCAC 27G.0603 &10A NCAC 27G.0604 - The Qualified Professional (#2) will be the first responder to any incident that occurs. All incidents will be addressed immediately. All incidents will be reported and documented in 24 hour window from the date and time incident occurred. All guardians are to be contacted immediately when an incident occurs. The Qualified professional (#2) will do an internal investigation for all level II and level III incidents within 24 hours and document it. The qualified professional (#2) will contact all appropriate individuals including the LME (Local Mangement Entity), DSS, LAW ENFORCEMENT, & the STATE within 24 hours and document appropriately. The Qualified Professional (#2) will develop and implement measures to prevent similar incidents from occurring effective July 25, 2019. 10A NCAC 27D. 0101- The Qualified Professional (#2) will contact all instances of alleged or suspected abuse, neglect or exploitation of clients and ensure they are reported to the County Department of Social Services effective July 25, 2019. As of July 25, 2019 the agency has decided to	V 293		

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V 293	Continued From page 19	V 293		

implement all addressed rules and regulations effective July 25, 2019. Also, the Qualified Professional (#2) will thoroughly supervise all staff and the owners, and reinforce rules and regulations as well as policy. The Qualified Professionals (#2)will also conduct pop ups on different shifts effective today July 25, 2019."

Center of Progressive Strides is a Residential Staff Secure treatment facility which serves clients requiring continuous supervision by at least 2 staff, behavioral intervention and a high level of support, to meet their needs. Assessment and treatment plans revealed issues of suicide attempts, defiance, oppositional behavior, inappropriate sexualized behavior, aggression towards family, severe property destruction, theft, and running away. Client diagnoses included Conduct Disorder; Obsessive Compulsive Disorder; Intellectual Developmental Disability; ADHD; Cannabis Use Disorder; Alcohol Use Disorder; Unspecified Anxiety Disorder; Autism; Post Traumatic Stress Disorder; Major Depressive Disorder and Disruptive Mood Dysregulation Disorder. On 5/20/19, client #2 disclosed to Licensee #1, Licensee #2 and the Qualified Professional he was touched inappropriately and sexually assaulted by former staff #11 on two separate occasions. Along with the client's mother, they questioned him extensively, stated they did not believe him and did not report the allegations to law enforcement or Child Protective Services. Their investigation which was not completed until 7/21/19 determined that the allegations were unfounded, and nothing occurred criminally. Client #2 was aware that Licensee #1 was the local police chief (assistant) and Licensee #2 was a local retired police officer. Client #2 disclosed the sexual assault in a forensic interview and then ran from

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V 293	Continued From page 20 the group home because the Licensees told him the police would not believe him and he should drop the charges. Former Staff #11 had been driving clients with a revoked driver's license and this was known by Licensee #2 who hired him. The weekend (5/17/19-5/19/19) that client #2 was sexually assaulted there was only 1 staff working during 5 different shifts. Licensee #2 was aware of the lack of appropriate staff supervision and did not provide the required coverage. 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 the facility is out of compliance beyond the 23rd day.	V 293		
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	V 296		

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V 296	Continued From page 21 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 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 review and interviews, the facility failed to have two direct care staff present while the clients were awake or asleep affecting 2 of 2 current clients (#1 and #2) and of 1 of 1 former client (FC #3). The findings are: Interview on 6/14/19 with the Licensee #2	V 296		

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V 296	Continued From page 22 revealed: - From 5/17/19-5/19/19 during 5 different shifts one staff worked. - "That was my bad on that (to have one staff on shift). That was a weekend (5/18/19 and 5/19/19) we were having staffing problems and I decided to wing it. That was my call on that." - On 5/17/19 from 4 pm-8 pm "[FS #11]worked that shift by himself because one of the employees called in." - On 5/17/19 from 8 pm-12 am FS #11 " (worked) by himself." - On 5/18/19 from 5 pm-12 am staff #6 " ...worked by himself." - On 5/18/19 from 12 am-8 am staff #10 " ...worked by herself." - Staff #5 was the only staff who worked on 5/19/19 from 8 am- 5pm. Interview on 6/19/19 with former staff (FS #11) revealed: - He worked part of the shift on 5/19/19 by himself because staff #1 left. - He worked alone on 5/19/19 from approximately 9:45 pm-11:30 pm. Interview on 6/7/19 with staff #1 revealed: - He worked the shift with FS #11 on 5/19/19 but left early to take his wife to work. - He was gone from approximately 8 pm-9 pm. Review on 6/7/19 of May 2019 staff schedules revealed: - Two staff were scheduled for all shifts in the month of May 2019. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 296		

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V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by:	V 366		

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V 366	Continued From page 24 (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the	V 366		

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V 366	Continued From page 25 LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based in interviews and record reviews, the facility failed to report a Level III incident to other authorities (Law Enforcement) required by law. The findings are: Interview on 6/6/19 with the Licensee #2 revealed: - After the group home staff learned on 5/20/19 about FS #11 possibly sexually abusing client #2, the staff did not notify law enforcement. - "Once Child Protective Services (CPS) Social Worker came in he said they would make all notifications. We didn't call law enforcement because we knew CPS was going to make all notifications on 5/20/19."	V 366		

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V 366	Continued From page 26 Review on 7/29/19 of the city police report dated 6/3/19 revealed: - The police report did not have a report of the allegations from the group home staff. - A report was received "from Guilford County DSS (Department of Social Services)." - The victim was listed as "[client #2]." - "On 5/28/19 this case was forwarded to [city] Police Department's Family Victims Unit in regards to Indecent Liberties of a child." This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 366		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy	V 500		

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V 500	Continued From page 27 that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention.	V 500		

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V 500	Continued From page 28 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure all instances of allegations of abuse were reported to the County Department of Social Services (DSS) and failed to report all level 2 incidents within 72 hours of becoming aware of the incidents affecting 1 of 2 current clients (client #2). The findings are: Interview on 6/6/19 with the Licensee #2 revealed: - On 5/20/19, when client #2 reported allegations of sex abuse to the Licensee #1, Licensee #2 and Qualified Professional they did not report it to Child Protective Services (CPS). - CPS Social Worker came to the home prior to the staff reporting it to the local Department of Social Services. - "CPS came in on 5/20/19 prior to us calling because we were going to call them the next day after we got all of our statements together. They came in around 8 pm on 5/20/19." Review on 6/5/19 of Incident Response Improvement System (IRIS) revealed: - "5/22/19: Provider agency indicates that incident was also given to County DSS." This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 500		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm,	V 512		

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V 512	Continued From page 29 abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, 1 of 1 former staff (FS #11) abused 1 of 2 current clients (client #2) and 1 of 1 former client (FC #3). The findings are: Review on 6/6/19 of client #2's record revealed: - Admission Date: 4/10/19 - Diagnoses: Conduct Disorder (D/O), Childhood Onset; Attention-Deficit/Hyperactivity Disorder (ADHD) Combined Type; Obsessive Compulsive D/O - Age: 15 years-old - Comprehensive Clinical Assessment dated 9/10/18 revealed: - " ...is currently on probation ...due to the severity of his behaviors consisting of aggression towards	V 512		

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V 512	Continued From page 30	V 512		

others, defiance towards rules and structure, destruction of property, theft and running away from home. "
- " ...mother has filed at least 16 missing person reports due to [client #2] running away.
- Review of client #2's goals in the Person-Centered Profile (PCP) updated 5/17/19 revealed:
- " ...will follow the rules of Level III placement."
- " ...will demonstrate improved decision-making skills..."
- " ...will decrease his disrespect for authority ..."
- " ...will participate in medication evaluation, individual/family therapy, and group therapy ..."
- " ...will have therapeutic leave with his family on a weekly basis as he progresses up the point/level system ..."

Review on 7/12/19 of FC #3's record revealed:
- Admission Date: 3/2/19
- Discharge Date: 6/5/19
- Diagnoses: Intellectual Developmental Disability, Mild; Attention-Deficit/Hyperactivity Disorder (ADHD) Combined Type; Cannabis Use D/O, Moderate; Alcohol Use D/O, Mild
- Age: 16 years-old

Review on 6/7/19 of FS #11's record revealed:
- Hire Date: 6/1/19
- Last day of employment: 5/19/19
- Paraprofessional
- On 5/1/18 sex offender search was "complete clear"
- Currently has a revoked driver's license and disposition date is 8/2/19.

Finding #1

Review of "Investigative Summary Regarding [Client #2]" written by the Licensee #2 dated

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V 512	Continued From page 31 7/21/19: - Signed by the Licensee #2 on 7/21/19 but as the "President-Co-Owner." - "On May 20, 2019, [client #2] contacted our House Supervisor [Qualified Professional (QP)] and advised her that one of our staff personnel, [FS #11] had touched him inappropriately." - "[The QP] then made contact with [the Licensee #1] at approximately 12:45 am and advised him of this allegation. [The QP] further stated that [client #2's mother], [client #2's] mother wanted to speak with [the Licensee #1] concerning this matter." - "[The Licensee #1] then immediately made contact with [client #2's mother] regarding this concern. [Client #2's mother] requested to know further details regarding the incident before she considered calling the police." - "[The Licensee #1] then proceeded to the facility to have conversation with [client #2] regarding this matter. [Client #2] indicated to [the Licensee #1] that on May 17, 2019 after 5 PM, [Former Staff (FS #11)] was transporting he and another client [FC #3] to drop off medication in High Point. This is when he (client #2) was touched by [FS #11] around his leg and private area. [Client #2] further stated that he was in the front seat while the other client [FC #3] was in the rear seat of the vehicle seated directly behind [FS #11]." - "[Client #2] further stated that he was forced to perform oral sex on [FS #11] on May 19, 2019 around 9 pm while at the facility. [Client #2] stated that [FS #11] stood up and told [client #2] to come over to where he was standing and grabbed his head and pulled his head down to his penis area." - "[Licensee #1] continued to question [client #2] further but [client #2] became more frustrated when [the Licensee #1] probed more regarding the allegation. [Client #2] also produced a cell phone that contained an audio recording of [FS	V 512		

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V 512	Continued From page 32 #11] that was provided to [the Licensee #1]. [The Licensee #1] stated he was unable to determine what was being stated on the recording." - "[The Licensee #1] also had conversation with [FS #11] and informed him of the allegations. [FS #11] denied the allegations and stated [client #2] is fabricating the entire event." - "[The Licensee #1] spoke to [client #1] and he advised that he did not see anything improper between [client #2] and [FS #11]. [Client #1] further stated that he came out of his room on several occasions and saw both of them (client #2 and FS #11) sitting in the living room watching television." - "[The Licensee #1] also spoke with [FC #3] and he stated he thought [FS #11]touch the leg of [client #2] or grab and possibly pull his penis out. [The Licensee #1] then stated [FC #3] started to laugh and started jumping up and down. The conversation then ended." - "[The Licensee #1] then called [client #2's mother] and advised he believed [client #2] was fabricating the incident. [The Licensee #1] then advised that he believed [client #2] was doing this in order to be removed from the facility. [Client #2's mother] then stated that [client #2] has lied on her and if she did not have proper documentation then she would have had serious issues." - "At the conclusion of the conversation, [client #2's mother] signed a document that she felt there was no criminal act to have occurred and she wanted our staff to continue to address the issue." - "This incident is currently being investigated by Child Protective Services, [Sheriff Department], and [Police Department]." - "After careful review of the aforementioned information I as the President (Vice-President) and Co-Owner of The Center of Progressive	V 512		

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V 512	Continued From page 33 Strides, Inc. facility shall declared this investigation as Unfounded and this matter is closed." Interview on 7/29/19 with client #2 revealed: - He was sexually abused by FS #11 on 5/17/19 and 5/19/19. - Three to four weeks prior to 5/17/19 and 5/19/19 sexual assaults, FS #11 had touched his butt "like four times before." - On 5/17/19 he was riding in the front seat of FS #11's car. FS #11 drove, and FC #3 was riding in the back seat behind FS #11. FS #11 grabbed client #2's penis twice once on the outside of his pants and once on inside of his pants. - "He (FS #11) tried to rub it (client #2's penis) on the outside first and I smacked his hands." - "He (FS #11) grabbed my penis inside my pants one time. I hit his hands and turned around to [FC #3] in the car and said, "did you see that?' " - "[FC #3's] mouth was dropped open and said 'bro.' " - Once they returned to the group home FC #3 told him, "you got to tell someone." - On 5/19/19 client #1 was in his bedroom and FC #3 was outside. Staff #1 left due to a family emergency and FS #11 worked alone. - On 5/19/19 client #2 was in the group home when FS #11: rubbed client #2's butt (over his pants); rubbed client #2's penis (over his clothes); suggest that he provide oral sex to client #2; exposed his penis to client #2; and then sat beside of client #2 and forced client #2's head down to his penis 3 times. Client #2 cried when FS #11 forced his head down to his penis and on the second time his (FS #11's) penis goes into client #2's mouth. - "[Client #1] was in his room with headset on he had like a recording studio in his room. [FS #11] had set up the recording studio. [FS #11] had	V 512		

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V 512	Continued From page 34 brought in a mixer for [client #1]." - "This is around like 9 pm-9:30 pm." - "[Staff #1] was there but left because his wife was in the hospital. [Staff #1] left around 8pm-8:30." - "It was on a Sunday because I had to go to school the next day." - "I was playing a video game (football) on the TV (television) in the den. [FS #11] was in the kitchen. I was standing close to the TV and [FS #11] came up and rubbed my butt (over his clothes)." - "I smacked at his hand and he said, 'you know you like it.' I was wearing yellow/black shoes and my black joggers and white shirt." - Then FS #11 rubbed his penis over his clothes. - "I said stop playing with me. I went and sat on the couch. He (FS #11) said if you sit over here, I will give you serious head for 3 minutes. " - "I was on the couch and I looked at him. I started playing (video games) again. He came up to me and dropped his pants and I scooted to the end of the couch. He was wearing white joggers/sweatpants with black dots." - "He (FS #11) sat down on the couch. He (FS #11) said, 'are you going to give me some?' I scooted onto the arm of the couch. (Client #1) came out of his room. Then [FS #11] ran to the hallway area." - "[FS #11] went and helped [client #1] with something and [FS #11] told [client #1] to stay in his room." - "[FS #11] asked me where [FC #3] was and I said, 'he is outside' and I just went outside and said to [FC #3] 'come in the house' and [FC #3] would not come in." - "[FS #11] came out and said to (client #2) come inside the house because there was no staff supervision and I said, 'no that's not true' about needing staff supervision because [FC #3] was	V 512		

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V 512	Continued From page 35 outside (alone)." - "[FS #11] started talking to [FC #3] and I went back inside, and I locked the door. [FS #11] had a key and unlocked the door. I was on the couch. [FS #11] came and sat down (to the right side of client #2). [Client #1] is still in his bedroom and [FC #3] was outside." - "I was playing the game. As soon as he sat down [FS #11] pulled down his pants and I said, 'Oh hell no.' He (FS #11) said let me talk to you and said, 'are you going to give me some head?' and I said, 'no I like girls.' He started forcing my head down. I said to myself in my head if I hit him, I am going to get the mess beat out of me because he's heavy set." - FS #11 pulled client #2's head down 3 times to his penis: - 1st time: "I pulled my head back and I have my lips balled up. I said (to FS #11) 'bro what are you doing?' and tears running down my face and I never thought I would be in the predicament. I have my hands (pushing) and try to get up and I can't. He was holding the back of my neck. I was shaking." - 2nd time: "He pulled me back down and that's when it (FS #11's penis) goes in my mouth." Denied anything came out of FS 11's penis. Client #2 pulled his head back up and "[FS #11] still has hold of the back of his neck." Client #2 could not remember if FS #11 said anything at this point. - 3rd time: "He pushed my head back down." Denied that [FS #11's] penis went in his mouth the 3rd time. "[FS #11] heard him (FC #3) on the porch (coming in the group home). [FS #11] ran and pulled up his pants. He (FS #11) went to the same area of the house when [client #3] came in (to the den from his bedroom)." - "[FC #3], sits down at the kitchen table to color a unicorn. [FS #11] told [FC #3], to go take a shower. [FC #3], said 'no.' I told[FC #3] to take a	V 512		

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V 512	Continued From page 36 shower." - "I went in the room and [FC #3], followed. I said I have something to tell you and I said (to FC #3), '[FS #11] made me do something to his d**k.' [FC #3] said 'you got to tell someone.' That's when I text my uncle. " - His uncle told him to "call me asap." His uncle told him to get a voice recording of FS #11. - He attempted to record FS #11 twice because the first recording was too long to send via text. - [FS #11] stated in one of the recordings, "since you are eating an ice cream sandwich you can stand up and whip it out and I can suck it." - It was difficult to hear the recording because the television was on and FS #11 was watching sports. - "When I tried to record him (FS #11), he showed me a video on Tumblr. Dudes messing with each other." The men in the video were naked having sex. - "I told him I don't want to see that, and he said people in gangs are gay they keep in a tight circle. He knows I am in the gang. I walked out of the room into the bedroom. Then [staff #9] came in and that's when I talked to [staff #9] and called my mom. - "I asked him (staff #9) what if a staff member inappropriately touched me and he said who [FS #11]? I didn't' have to tell him he knew. It was not the first time [staff #9] heard this from a kid in the group home." Staff #9 did not provide client #2 the name of the other child. - Denied that he ever told FS #11 about his past or that he was sexually abused. - "I told [FS #11] nothing about my past." Interview on 6/13/19 with staff #9 revealed: - He came on shift about midnight on 5/20/19 and FS #11 was the only staff member coming off shift before him.	V 512		

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V 512	Continued From page 37 - Client #2 told him he was not comfortable around FS #11 because FS #11 asked him to pull out his penis. - Client #2 woke up FC #3 to tell what FS #11 did to him. FC #3 reported what client #2 told him which was FS #11 asked to see client #2's penis. - "[Client #2] said, [staff #9] 'could I ask you something? What do you think about a staff saying something inappropriate to me?' " - "He (client #2) was telling me he felt uncomfortable around [FS #11] because he said something inappropriate to me." - "[Client #2] said [FS #11] said that he was asking him (client #2) to pull out his penis or let him see it or something like that." - "[FC #3] said [FS #11] said to let [FS #11] see [client #2's] penis ...[FC #3] said that's what [client #2] said.' Interview on 7/24/19 with client #2's uncle revealed: - On 5/19/19, he received a text first from client #2 and then he called client #2. - Client #2 told him FS #11 made him perform oral sex on him. - He had advised client #2 to record FS #11. - "Another boy in the room who would not say his name said that it did happen (the same thing client #2 said)." - "[Client #2] said that a staff ...[FS #11] had made him [client #2] suck his (FS #11's) d**k. I told him (client #2) you should have punched him or bit it." - "I told him to record it (what FS #11 stated) so you will have it on tape, and no one will question you." Review on 7/25/19 of the text messages between client #2 and client #2's uncle revealed: - On 5/19/19 at 11:13 pm text message from client #2 to his uncle: "Listen now IK (I know) how	V 512		

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CENTER OF PROGRESSIVE STRIDES	2212 GLENSIDE DRIVE GREENSBORO, NC 27405

(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 512	Continued From page 38 I roll but I can't do this place no more Bc (because) one of the male staff force me to suck his d**k while one of the boys was in there room an one was outside An this was tonight." - On 5/19/19 at 11:22 pm text message from client #2's uncle to client #2: "Call me asap." - On 5/19/19 at 11: 29 pm text message from client #2 to his uncle: "He just ask me was I coming through he said if we gonna do something do it now Bc (because) the orther staff come in soon." Interview on 6/24/19 with client #2's mother revealed: - She was contacted on 5/20/19 at 12:04 am by her son (client #2). - Client #2 made her aware that FS #11 sexually abused him and she contacted the QP, the Licensee #1 and an unknown staff. - "He (client #2) told me that I needed to get up there because one of the staff was trying to make him suck his penis and I said I would call you back." - Client #2 identified that staff as FS #11. - She called the QP - "I told her (the QP) I was about to call the police and she said let me call the [the Licensee #1] first." - While waiting for the Licensee #1 to call her she called the group home and talked to an unknown staff member who told her "[Client #2] said [FS #11] did make [client #2] place his mouth on his penis." - While waiting on the Licensee #1 to call her she talked to her son (client #2) again who reported: - On the Friday before (5/17/19) FS #11 was driving to another client's home. Client #2 was sitting in the front passenger seat and another client was sitting in the back (which side is unknown to her).	V 512		

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V 512	Continued From page 39 - Client #2 told her FS #11 twice tried to fondle him put his hands down client #2's pants and client #2 moved his (FS #11's) hand twice. - "[FS #11] would show them videos of pan genders. Men dressed as women. [FS #11] told them that pangender was someone who didn't see gender. [Client #2] said the video was men having sex with men." - "[FS #11] would show videos to him and [FC #3]." - She went to a meeting at the group home the morning of 5/20/19 where a recording that client #2 made was played. - The recording was difficult to hear, and she only heard "the shift is getting ready to change pull it out." - She was unsure what "pull it out" meant because client #2 had gotten an ice cream sandwich out of the freezer. Interview on 6/7/19 and 6/18/19 with the QP revealed: - She was called on 5/20/19 at 12:27 am by client #2's mother "who stated her son (client #2) had contacted her saying [FS #11] had inappropriately touched him on Friday (5/17/19) and Sunday (5/19/19)." - She had a meeting on 5/20/19 at 8 am with client #2, client #2's mother, the Licensee #2 about what occurred on 5/17/19 and 5/19/19. - In the meeting client #2 told them on 5/17/19 the following occurred: - " ... [FS #11] and himself (client #2) and [FC #3] went to drop off medication at [client #1's] home. He said on the way there that [FS #11] grabbed his d**k and started playing with it. [Client #2] said he turned around and looked at [FC #3] in the back seat and that [FS #11] pulled his hand away. [FC #3] reported that [FC #3] was behind [client #2] in the car."	V 512		

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V 512	Continued From page 40 In the meeting client #2 told them on 5/19/19 the following occurred: - "[Client #2] said [FC #3] went out of the house. [Client #1] was in his room. [client #2] standing at the TV playing video games and [FS #11] came up behind him and rubbed on his butt." - "Then [client #1] came out of the room, [FS #11] talked to [client #1] a little bit and then [FS #11] took [client #1] back to his room." - "When Mr. [FS #11] came back into the den [client #2] sat on the couch so that he (FS #11) would not touch him again." - "Then he (client #2) said [FS #11] sat down on the couch with him (client #2) and told [client #2] to come closer to him. [Client #2] told [FS #11] 'nah I am good.' " - " ...[client #2] said '[FS #11] scooted closer to him while [FS #11] pulled down his own pants.' [Client #2] said 'he tried to get up [FS #11] pulled him down and said just try it one time.' " - "[Client #2] said 'he tried to get up again and [FS #11] pulled him back down again and hit him (client #2) in the face with his (FS #11's) d**k.' " - "[FS #11] kept pushing his head down to the point he had no choice but to put his mouth on it (FS #11's penis)." - " ...[client #2] said 'I had no choice but to put my month on it and to go up and down and you know what I mean.' " - "He said '[FC #3] came in through the front door and [FS #11] pulled up his pants. After that he (client #2) told us he went in the bathroom took a shower and then stayed in his room until he came out and asked [FS #11] if he could have an ice cream sandwich. He ate the ice cream sandwich and went back into his room." - "[Client #2] reported [FS #11] came in there and told him 'we could try again before 3rd shift staff came in.' "	V 512		

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V 512	Continued From page 41 - "[FC #3] came out of the bathroom (they share a room and bathroom) and [FS #11] left the room. Then 3rd shift came in." Interview on 6/6/19 with the Licensee #2 revealed: - He woke up about 3 am and received several text messages from the QP and the Licensee #1 during the night on 5/20/19. - The Licensee #1 told him that Client #2 had alleged on 5/19/19 between 8:30 pm- 9 pm while at the group home FS #11 had touched him inappropriately. - Client #2's mother had contacted the Licensee #1 with concerns her son had been inappropriately touched. - Client #2 had text his uncle and his grandmother and told them something inappropriately had happened with staff. - He interviewed client #2 who reported the following: - "(On 5/17/19) ...[client #2] was in the front passenger seat with [FS #11] and [FC #3] riding in the back. [Client #2] alleged that [FS #11] reached down into his pants and touched his penis. [Client #2] said that [FS #11] did that and then stopped and continued driving." - He then interviewed FC #3 who reported the following: - "Around 7:50 am I talked to [FC #3] on 5/20/19. I asked him (FC #3) if anything happened inappropriate and he said, 'I was sitting in the back seat and it could have happened.' Then he dropped his head and said, 'I will be honest we talked about setting up [FS #11] and getting him in trouble so [client #2] can go home and get out of the group home.' " - After he interviewed FC #3, he talked to client #2 and told him: - "I said [client #2] if something happened	V 512		

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V 512	Continued From page 42	V 512		

inappropriate, we need to go forth and if it didn't and you are making it up that could be a major problem. He (client #2) said I know that's right I am not making this up, it happened last night. (I said to client #2) once your mom gets here, we are going to talk as a group and get to the bottom of this."
- On 5/20/19 during a meeting he had with client #2, client #2's mother and the QP, client #2 reported:
- "He (client #2) said they (client #2 and FS #11) were watching TV. [FC #3] had a lot of nervous energy and was coming in and out when [client #2] and [FS #11] were watching TV (5/19/19). [Client #2] was in his room listening to music on 5/19/19 during this time. [FS #11] was sitting on the couch in the den and [client #2] was standing up and he said [FS #11] pulled his head down towards his private area and made him perform oral sex with him. [Client #2] said that [FS #11] pants were pulled down to his knees.
- "I (the Licensee #2) said (to client #2) you're in a gang your 6'2" and [FS #11] is 53 and short and had knee replacements. I said if you are standing up, how is he able to, sitting down...was he able to pull you down?"
- "He (client #2) responded by saying, '[FS #11] is strong and I was scared of him.' "
- "Then we asked about the incident in the car on 5/17/19. (I said) ...he (FS #11) pulled up your shirt and goes down your pants and you did not say anything or try to stop him? (I said) You (client #2) didn't say to [FC #3] to look at what he was doing and he (client #2) said 'no.' "
- "We found it hard to believe because as big as he is/being in a gang and all the fights he has been in."
- On 5/20/19 he talked to client #1 about the 5/19/19 incident:
- "[Client #1] said he was in room and came out 3

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or 4 times when [client #2] and [FS #11] were watching TV (on 5/19/19)."
- "I asked him (client #1) if he saw anything inappropriate and he said no they were watching TV."
- "[Client #2] had a cell phone he wasn't supposed to have, and he said he recorded [FS #11] making inappropriate statements. I listened to it and it said something like 'pull something out' but I could not make out. The mother (client #2's) and [QP] said they could hear it and they heard 'stand up and pull it out.' "

Interview on 6/19/19 and 7/24/19 with FS #11 revealed:
- He did wrestle with client #2 one time but did not write up an incident report when this occurred.
- "One time [client #2] grabbed me from the back. I tossed him over my shoulder, and he landed on the floor and he jumped up real fast and said, 'you can move for an old guy.' "
- He denied having any inappropriate sexualized contact with client #2.

Interview with the Licensee #1 on 6/11/19 revealed:
- On 5/20/19 at approximately 12:27 a.m. he received a call from the QP that FS #11 has allegedly sexually abused client #2. After the 5/20/19 phone call with the QP, he drove over to the group home and interviewed client #2.
- After he interviewed client #2, he did not believe him because there was "a major discrepancy" between what client #2's mother said and what was said by client #2.
- "On Monday (5/20/19) Morning 12:27 a.m. I got a phone call from [QP] on my home phone. (The QP said) 'Client #2's mother is going to call the police about our group home.' "
- "I get up and I said, 'what's going on?' She

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V 512	Continued From page 44 (Client #2's mother) is saying something about an encounter with [client #2] and one of the staff. She (client #2's mother) said something inappropriate happened between the staff and [client #2]." - "I call the mother and told her I am on the way to the group home. The mother (client #2's mother) said, '[Licensee #1] one of your staff tried to make him (client #2) perform oral sex with him.' " - "I asked, 'her which staff?' She said, 'that's all I can tell you and she said she just want to make sure he is safe.' " - "I said 'we don't know if anything happened let's talk to the staff and I said let me go to the group home and talk to [client #2] and then I will call you." - "I talked to [client #2] outside (on 5/20/19). (I said to client #2) your mom said there was an incident between you and [FS #11]. " - "(Client #2 said,) 'he (FS #11) made me suck his penis ... He (FS #11) grabbed my head and he pushed it down to his penis.' " - "So, I noticed a discrepancy. The mother (client #2's mother) said 'tried' and [client #2] said 'he did it.' I said your mother said 'tried' and you said, 'he did it.' " - "He (client #2) then had a long pause. He seemed to be gathering his thoughts. Then he said, 'no no he made me do it.' - "(I said,) 'before I call your mom back you are telling me he grabbed your head and he made you do it. You didn't try to stop it or put up a fight or anything?' And he said 'no.' I said that's kind of strange with you because your stature." - "I (Licensee #1) told him to go back in the house. I called the mother and said, 'you said he tried to do it' and he said, 'he did do it.' [Client #2] said to the mother he tried to do it. There was a major discrepancy there between trying and doing."	V 512		

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V 512	Continued From page 45 - "[Client #2] had a phone (that information came from the mother) and he had something on the phone. I got the phone from [client #2] but could not make out what was on the phone. I told her (mother) I will have the phone for you when you come tomorrow." - He also did not believe client #2 because he felt client #2 made up the incident to get out of the group home: - "I don't think anything occurred because he wanted to get out of the group home because he knew he wasn't going to play football if the phone was found and I had a come to Jesus meeting with him about that. If he realized his free time was going to be taken away, he wanted to be out of there and I told her (client #2's mother) I feel he is using this as a launching pad to get out of the group home." He interviewed FC #3 on 5/20/19: - "[FC #3] wanted to talk about the incident and I said what happened and he smiled. He said [the Licensee #1,] [client #2] wanted me to lie for him so he could get out of the group home. I said you plan this and he said we have been planning this for a while. [FC #3] said [client #2] wants to get out of the group home and doing whatever he needs to do to get out. I asked [FC #3] why was he willing to lie for [client #2] he said because he is my brother. I said he is willing to lie on my staff member and he said yes, he [client #2] is." "I don't think this incident happened at all and nothing occurred criminally." Observation on 6/24/19 at approximately 2:00 pm of client #2's forensic interview revealed: - He provided his cell phone to the detective at the end of the forensic interview. Review on 7/23/19 of Child Protective Services (CPS) social worker's interview dictation of FC #3	V 512		

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V 512	Continued From page 46 dated 7/2/19 revealed: - CPS Social worker interviewed FC #3 about the two incidents. She interviewed FC #3 about the incident on 5/19/19 first and then the 5/17/19 incident. FC #3 reported: - "[FC #3] reports that [FS #11] touched [client #2]. He (FS #11) never touched [client #1]." - "He (FC #3) thinks one incident happened on Saturday but doesn't remember the day, he was outside and came back in [client #2] was in the room crying and he asked what was wrong. [Client #2] said [FS #11] made him suck his private part." - "[FS #3] stayed in the room the rest of that day until the other staff came in- [staff #1] and [staff #9]." - "[Client #2] told staff what happened. They called the owner - [the Licensee #1] and he came. When [the Licensee #1] got there, he talked to him (FC #3)- first and then [client #2]." - "One day they rode to take [client #1] his stuff all the way to High Point- (stuff- music). [FS #11] took him (FC #3) and [client #2] to [local city], NC." - "[FS #11] (was in the) driver seat, [client #2] in passenger seat [FS #11] touched [client #2's] private part. He [FC #3] seen it but didn't say anything. [FS #11] touched him on the inside of his clothes." - "Doesn't remember what they were wearing. It was day time when this happened. [Client #2] kept saying 'stop.' [Client #2] called the owner- he thinks [the Licensee #2) but not sure- when they got to the house. No one came to talk to him about the incident." - "The incident in the car happened first before the incident in the house. He [client #2] asked should he tell and [FC #3] told him that it was his choice. The second incident he [client #2] asked if he should tell and he stated the same thing.	V 512		

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V 512	Continued From page 47 [Client #2] told on both occasions." - "He denies anyone ever talking to him about the allegations. " Interview and observations on 6/7/19 of client #1 revealed: - At approximately 2:01 pm he immediately stated with no questions asked, "the thing that was said about one of the staff is not really true. He hasn't done it to me or any of the other clients before... " - He was not in the car on the day FS #11, client #2, FC #3 drove to his family's home and brought him medication (5/17/19). - On 5/19/19 he did not see anything and feels client #2 and FC #3 made up the story about client #2 being sexually abused by FS #11 because they wanted to leave the group home. - "I came out of my room three times (on 5/19/19) and I didn't see anything go on. From what I feel I feel it was told as a lie because the boys (client #2 and FC #3) were wanting to get up out of here and they are not doing good." - "No (I did not hear client #2 and FC #3 say they were going to lie) but I feel like that because they plot about a lot things about ganging up on me but staff always help me." Interview on 6/10/19 with FS #11 revealed: - On 5/17/19 he drove to client #1's home to take him his medication. He took client #2 and FC #3 with him in the car. Client #2 rode in the front passenger seat. No other staff were present in the car. - He denied any physical contact with client #2 during the car ride but did reach over to his "glove compartment" (in front of client #2) to get some allergy medication. - "I reached over and took the Allegra bottle and was trying to open it and [client #2] said 'man give it here' and he took it and opened it for me. He	V 512		

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V 512	Continued From page 48 (client #2) handed me the Allegra and I took it with my drink. He put the lid back on the Allegra and then handed back to me and I said, 'why did you do that' and I put it in the glove compartment." - On 5/19/19 he reported he worked alone from "about 9:45 pm- until around 11:30 pm when [staff #9] got there." - He denied having any physical contact with client #2 on 5/19/19. - While working alone, he and client #2 were in the den. FC #3 was outside refusing to come in and client #1 was in his room but came out three times. - Client #2 had told him, he was not staying at the group home "the whole fn summer." - When he explains to client #2 "that's on your mother (if you go home)" Client #2 told him when he was younger that she used to send him over to some guys house. And he said the guy eventually molested him. - Then client #2 told him he needed to go back to his grandmother's home in [North Carolina County] "because someone was fn with his grandma." - Eventually FC #3 comes into the group home and client #2 is playing video games. - Client #2 argues with FC #3 about taking a shower. - While he was still the only staff working client #2 tells him he moved out of FC #3's room "because one night he (client #2) woke up and [FC #3] was trying to stick his penis in his (client #2's) butt." - Client #2 told him he moved back into FC #3's room the day before because "he (client #2) felt like something was biting him in the other room." - Toward the end of the shift client #2 and FC #3 were in the bedroom together and he hears yelling and goes into the bedroom. - "So, I knock on the door and [client #2] has	V 512		

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V 512	Continued From page 49	V 512		

towel on and screaming and yelling at [FC #3]. At first, I didn't see [FC #3]. [Client #2] said 'tell that MF if he keeps fn with me I will f him up for real.' I said, 'what in the world.' [FC #3] was standing in the closet. [Client #2] slammed the door to the bathroom. [FC #3] was looked petrified and looked like he had seen a ghost." He never found out what occurred between FC #3 and client #2.
- He sat down to do notes and is still the only staff on duty. He doses off but wakes up to FC #3 coming out of the room and "slamming the door." Client #1 brings him recording equipment for him to lock up.
- He started watching television and "doses off again" and he is still the only staff on duty.
- He was awoken by client #2 standing beside of him eating ice cream sandwich.
- Staff # 9 then came on shift.
- When he arrived home, he received a call from the QP about the accusations and was then suspended.

Finding #2

Review on 7/31/19 of Child Protective Services social worker's interview dictation of FC #3 dated 7/2/19 revealed:
- FS #11 wrestled with FC #3.
- FS #11 touched FC #3's private parts.
- "[FC #3] reports that he played a lot with [FS #11] They would fake punch, pick each other up and slam each other on the couch. (On) School days just him and [FS #11] - if [FC #3] was suspended from school. [FC #3] would put his hands on [FS #11's] legs- because he's big he would grab him by his legs. [FS #11] would grab him by his stomach. "
- "[FC #3] would be in the kitchen and [FS #11] would start touching him (FC #3) on his private with his palm. He (FS #11) would touch over his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-807	A. BUILDING: _____ B. WING _____	C 07/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER OF PROGRESSIVE STRIDES	2212 GLENSIDE DRIVE GREENSBORO, NC 27405

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V 512	Continued From page 50 clothes." - "Did not remember what he was wearing or what [FS #11] was wearing." - "[FC #3] reports that he would never tell him to stop he would just go outside and wait until everyone got home off the bus. He (FC #3) did not remember how many times this happened." - - "[FS #11] asked him 'did it feel good' he didn't answer he went outside. No other staff in the home. He was suspended- he remembered going to school that day but was suspended and had to go home early." Interview on 7/24/19 with FS #11 revealed: - The only physical contact he had with FC #3 was when FC #3 tried to grab him. - He did not write an incident report when FC #3 grabbed him. " ....[FC #3] tried to grab me all the time and I would push him off and tell him to chill out." Review on 7/25/19 of the Plan of Protection dated 7/25/19 and written by the Qualified Professional #2 revealed: What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? Describe your plans to make sure the above happens. 10A NCAC 27D. 0304 - The Qualified Professional (#2) will ensure that all employees of Center of Progressive Stride shall protect clients from harm, abuse, neglect and exploitation. Center of Progressive Stride Employees shall not subject a client to any sort of abuse or neglect; this includes verbal abuse. All allegations shall be reported to the Qualified Professional (#2)	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 512	Continued From page 51 immediately. Any violation of this rule shall be grounds of dismissal of the employee immediately, effective July 25, 2019. As of July 25, 2019 the agency has decided to implement all addressed rules and regulations effective July 25, 2019. Also, the Qualified Professional (#2) will thoroughly supervise all staff and the owners, and reinforce rules and regulations as well as policy. The Qualified Professionals (#2) will also conduct pop ups on different shifts effective today July 25, 2019." Center of Progressive Strides is a Residential Staff Secure treatment facility which serves clients requiring continuous supervision by at least 2 staff, behavioral intervention and a high level of support, to meet their needs. Assessment and treatment plans revealed issues of aggression, defiance towards rules and structure, destruction of property, theft and running away from home. Client diagnoses included Conduct Disorder; Obsessive Compulsive Disorder; Intellectual Developmental Disability; ADHD; Cannabis Use Disorder and Alcohol Use Disorder. On 5/17/19 while riding in the car with a former client, client #2 was sexually molested as he was grabbed twice in the groin area (over and under his pants) by Former Staff #11. On 5/19/19 a second assault occurred while in the group home as the same staff rubbed client #2's butt (over his pants); rubbed client #2's groin (over his clothes); suggested that he provide oral sex to the client; exposed himself and then sat beside client #2 and forced him to engage in oral sex. Former Client #3 confirmed during interview that client #2 was sexually assaulted by Former Staff #11 on the two occasions. This former client also reported the same staff sexually assaulted him as he rubbed his private parts over the client when other staff were not present.	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 512	Continued From page 52 This deficiency constitutes a Type A1 rule violation for serious abuse 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 the facility is out of compliance beyond the 23rd day.	V 512		