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V 000	INITIAL COMMENTS A complaint survey was completed on 7/16/19. The complaint was substantiated (Intake # NC153379). 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 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations;	V 105		

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V 105	Continued From page 1 (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field; This Rule is not met as evidenced by: Based on record reviews and interviews, the	V 105		

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V 105	Continued From page 2 facility failed to develop and implement written policies for admission based on current census, acuity and ability to meet the individual needs for 2 of 7 Clients (Client #1 and #2). The findings are: Record review on 7/9/19 for Client #1 revealed: Admission Date: 08/23/18 Discharge Date: 6/24/19-discharged to detention as a result of 6/14/19 incident. Diagnoses: Conduct Disorder, Attention Deficit Hyperactivity Disorder (ADHD) combined type, Generalized Anxiety Disorder (GAD), Tourette's Syndrome, Perpetrator of non-parental sex abuse of a child. Age: 14 History: Referred for offender specific treatment December 2017 due to harmful sexual behavior towards sister and Client was adjudicated with two counts of sexual battery. Referred to Level 3 residential after initial outpatient treatment was deemed unsuccessful due to lack of motivation and safety concerns that resulted in a probation violation. Record review on 7/9/19 for Client #2 revealed: Date of admission: 6/14/19 Age: 16 Diagnoses: Conduct Disorder, Attention Deficit Disorder. History: Referred for offender specific treatment February 2018 due to harmful sexual behavior towards a younger female, age 5, and Client was adjudicated one count of Indecent Liberties between children. Referred to Level 3 residential after initial outpatient treatment was deemed unsuccessful due to continued legal issues resulting in court involvement (larceny), multiple school absences, verbal aggression towards others and a report of inappropriately touching a	V 105	On 7/23/2019, company updated established policy and procedure to include more concise written criteria for Residential Level III sex offender home room placement. This procedure outlines how all youth high risk and new admissions will be housed within the facility. It covers single occupancy rooms, double occupancy rooms, how to select which clients may share rooms, emphasizes importance of staff supervision and direct line of sight. Further more, this procedure also addresses expectations for staff during shift changes and if no viable rooms are available to ensure safety. See attached policy. Policy # 7-007 Supervision Protocol and Room Assignment for 24 hour surveillance. Responsible party QI Director, NC Program Director, and Residential Coordinator. 7/23/2019 - Held mandatory Group Supervision from 10:00am to 12:00pm discussing many issues within the home including the Governing Body Policy around room placement and supervision with all floor staff and therapist. Responsible party Residential Coordinator and Lead QP. 7/23/2019 - From 2:00pm to 3:30pm, meet with Lead QP in a individual supervision, discussed the results of the investigations, what expectation are expected going forward, how in the future she is to always go through the therapist, Residential Coordinator and Program Director before making a decision for room placement. Reviewed the Governing Body Policy and explained it in detail with the Lead QP. Responsible party Residential Coordinator.	

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V 105	Continued From page 3 female at school. A Crisis Plan updated 6/6/19 prior to admission into the facility reports an environmental trigger of "unfamiliar social settings" and an interpersonal trigger noting "history of attachment issues and does not adjust well to change." Review on 7/9/19 of Incident Response Improvement System (IRIS) report for incident on 6/16/19 revealed: "On 6/16/19 at approximately 9:45PM, [Staff #5] was conducting a bed check and observed [Client #1] in [Client #2]'s bed on top of [Client #2] under the covers. [Staff #5] asked [Client #1] what he was doing at which time [Client #1] jumped from the bed and ran across the room. [Staff #5] stated that she saw that [Client #1] did not have pants or underwear on. [Staff #5] told [Client #1] to step out of the room and into the milieu. [Client #1] started yelling at [Staff #4] that [Staff #5] was a liar. [Client #1] then went outside and started punching the house. Supervisor was contacted immediately, and statements were written from both consumers as the staff monitored and observed them. Residential House Lead [Qualified Professional] called local police department. Deputies came out to the house, read the statements and gathered information on the consumers and staff. Deputies indicated they would return later that afternoon to set up an interview with each consumer. Deputies have yet to return. Staff separated both consumers and now have alternate sleeping arrangements." Client #1's statement revealed "It all started I was masturbating and he saw me and he asked me to masturbate with him. I said OK so then he said let me suck your penis. I put my hand on his head and then I asked if he wanted to have oral sex and he said yeah so I bent over and he put his penis in my butt. Then you started humping me	V 105	Starting the week of 6/16/2019, immediately following this incident, the Program Director and Residential Coordinator determined that weekly staff meetings must be conducted in order to staff all high risk cases. Weekly staff meetings have been occurring weekly since that week. Minutes are available upon request. This is to establish sexually high risk patterns and to continually staff rooms for the possible of high risk issues. In the past staff were only meeting one time monthly, this was due to limited financial resources and keeping overtime at a minimum. Human Resources is responsible for keeping the completed minutes. New mandated requirements: Staff will sit in halls until the hours of 2am-3am at which time they will begin monitoring the halls at irregular times so clients do not become accustom to staff routine. There will be staff in Hallway A and Hallway B sitting directly outside client rooms. From hours of 3am-6am (when clients awaken) staff will monitor halls at irregular intervals every 7 to 15 minutes. A nightly log will be completed throughout the entire night, for both Hallway A and Hallway B, requiring staff signature and initials. If a staff has to go downstairs to do chores or go to the restroom the other staff is required to walk all hallways the entire time until second staff returns. AEB: Camera Logs, Responsible party being QI Director, Lead QP, Residential Coordinator, and Program Director 6/24/2019 - Order petitions 6/27/2019 - Petitions arrived and was taken to the home and placed in each double occupancy room 7/10/2019 - Petitions were affixed to the walls so clients could not move or manipulate them 6/24/2019 - Ordered motion sensitive lights for double occupancy rooms. 7/2019 - Motion sensitive lights were installed.	

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V 105	Continued From page 4 and so I said yes Daddy to him and then he cum on me and then turn around and I started to masturbate him. I said you already cummed and he said yeah and fell asleep. I was still hard so I took off my shorts and humped his face. I did it multiple times." Client #2's statement revealed that "Yesterday, we were going to bed and [Client #1] was playing with his penis while were all supposed to be in bed. Today, [Client #1] was trying to get me to engage in his negative behaviors. First he said he was going to act out, [Client #1] stated 'you aint never seen me act out'. Then he was masturbating on his bed and I told him to stop a couple of times, he didn't so I pretended to be asleep. While doing that [Client #1] was poking and whispering my name after that didn't work he started to get up multiple times out of his bed. [Client #1] without my consent in the first place, was putting his penis and genitals in my face, while putting his mouth over my penis and stroking it. I said no multiple times and he did it over and over. Before staff noticed what he was doing he had ejaculated on my nose and cheek. I wiped it off when staff came in the room." Interview on 7/9/19 with Lead Qualified Professional (QP) revealed: -Normally newly admitted Clients got their own room for the first 30 days, but this was not possible for Client #2's admission to the facility. The facility already had "two aggressors" in single rooms with whom the Lead QP noted it would not have been appropriate to put a new Client. - Client #1 was chosen to share a room with Client #2 as Client #1 had not shown any behaviors since his last incident with Former Client (FC) #8 in November 2018. -The Lead QP was aware that Client #1 had previously engaged in sexual behavior when in a	V 105		

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V 105	Continued From page 5 shared room with Client #8. - Client #1 was reported to have been making progress since December 2018. -Client # 2 was coming from Therapeutic Foster Care (TFC) and it was reported he was known to be "more vulnerable" as he had never been in a facility. The Lead QP reported FC #8 had also come from a home environment and was new to the facility when the incident occurred with Client #1 in a shared bedroom. -Lead QP reported she did not think Client #1 would struggle with a roommate again. Client #1 was asked by Lead QP if he could handle a roommate and Client #1 stated it was fine. - Client #1 was "the best option at the time" due to the other high-risk sexual behaviors already being exhibited in the house by other Clients who required single occupancy rooms. -The Lead QP made the final decisions on roommates. -The Lead QP was not aware of a written policy that states a new Client gets a single room for 30 days, but notes the facility tries to give new Clients a single room. Interview on 7/16/19 with the Residential Coordinator (RC) revealed: -"If it's at all possible, the facility tries to place new admissions in a bedroom by themselves for the first 30 days, so that staff can get to know the Client and their behaviors." -It's a "rule of thumb" to give new Clients their own room if possible. There may be emergency/court ordered out of home placements that warrants taking a new Client when a single room cannot be accommodated. -After reviewing admissions for the past 6 months, the only other admission that did not have a single room, had shared a room with Client #1 and was also offended.	V 105		

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V 105	Continued From page 6 -There is no written policy that states a new Client gets a single room for 30 days, but it's a procedure. -To her knowledge, the facility had never postponed an admission date to be able to accommodate giving the new Client a single room. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 violation and must be corrected within 23 days.	V 105	Policy # 7-007 Supervision Protocol and Room Assignment for 24 hour surveillance. Now addresses mandated protocols if a client cannot be safely placed in a double occupancy room and there is no single room available. Residential Coordinator and QI Director is responsible for revision of Policy and Procedures.	
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	V 109		

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V 109	Continued From page 7 MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record reviews and interviews 1 of 1 Qualified Professionals (Lead QP) failed to demonstrate knowledge, skills and abilities required by the population served by failure to have effective safety measures in place for new resident and failure to ensure client specific training was provided to all staff. The findings are: Record review on 7/9/19 for Client #1 revealed: Admission Date: 08/23/18 Discharge Date: 6/24/19 Discharged to detention as a result of 6/14/19 incident Diagnoses: Conduct Disorder, Attention Deficit Hyperactivity Disorder (ADHD) combined type, Generalized Anxiety Disorder (GAD), Tourette's Syndrome, Perpetrator of non-parental sex abuse of a child. Age: 14 History: Referred for offender specific treatment December 2017 due to harmful sexual behavior towards sister and Client was adjudicated with two counts of sexual battery. Referred to Level 3 residential after initial outpatient treatment was deemed unsuccessful due to lack of motivation	V 109	Residential Coordinator started frequent clinical supervisions for additional training on sex offender specific treatment with the Lead QP on the following dates 7/23/2019, 7/30/2019, 8/6/2019, and 8/13/2019. This will continue until the Residential Coordinator, QP and Director feel she is better trained and prepared to work independently. Supervisions available upon request. Lead QP also recieved additional PCP training on August 1, 2019. Lead QP is also scheduled to attend Problem Sexual Behavior Training with Clinical Director, Francine Kaurba, LCSW on August 23, 2019. It is an 8 hour training.	

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V 109	Continued From page 8 and safety concerns that resulted in a probation violation. See Tag V112 for additional information regarding treatment planning. Record review on 7/9/19 for Client #2 revealed: Date of admission: 6/14/19 Age: 16 Diagnoses: Conduct Disorder, Attention Deficit Disorder History: Referred for offender specific treatment February 2018 due to harmful sexual behavior towards a younger female, age 5, and Client was adjudicated one count of Indecent Liberties between children. Referred to Level 3 residential after initial outpatient treatment was deemed unsuccessful due to continued legal issues resulting in court involvement (larceny), multiple school absences, verbal aggression towards others and a report of inappropriately touching a female at school. A Crisis Plan updated 6/6/19 prior to admission into the facility reports an environmental trigger of "unfamiliar social settings" and an interpersonal trigger noting "history of attachment issues and does not do adjust well to change." See V111 for additional information regarding treatment planning. Record review on 7/12/19 for Lead QP revealed: -Date of Hire 11/22/17. Hired as Associate Professional. Earned QP status 9/11/18. -Became Case Manager and Lead QP of this facility 3/1/19. Record review on 7/9/19 of Licensed Practitioner (LP)'s progress notes for Client #1 from 4/16/19-6/18/19 revealed:	V 109		

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V 109	Continued From page 9 -4/16/19: Client #1 was open about how he has been staying highly sexual recently. -4/19/19: Client #1 went over his disclosures with the therapist. -4/23/19: Client #1 worked on impact essay. -4/30/19: Client #1 feels he cannot get his mind off masturbating. -5/14/19: Client #1 continues to have difficulty with consistently having erections. Completed letter to victim. -5/21/19: Client #1 continues to have urges at night and is having wrong time-wrong place. -5/25/19: Client #1 admitted how he has been doing wrong time-wrong place. He continues to have extreme issues with controlling his sexualized urges. He tends not to use his coping skills at times. - 5/30/19: Client #1 continues to do wrong time-wrong place due to his feeling he cannot control his urges. -6/6/19: Client #1 continues to have sexualized thoughts and he explained someone has seen him masturbating. -6/8/19: Client #1 stated he continues to have issues with constant erections and is unsure what to do about them. -6/9/19: Therapist supported Client #1 going over his disclosures to a family member. Review on 7/9/19 of the "Pass Along Notebook" from 6/1/19 to 6/15/19 specific to Client #1's status in the program prior to being selected to share a room with Client #2 revealed: - Client #1 was only "In Order" or compliant with program rules 3 times/shifts in 15 days. -Staff #4 explained the "In Order" status with "most kids fluctuate in/out of order daily or within a 24-hour period." - Client #1 did not fluctuate being in compliance with program rules in a 24-hour period, as he only	V 109	On 7/23/2019, a mandatory staff team meeting was conducted with all floor staff at Burkwell facility, they were notified that pass-a-long documentation must be completed for every shift, must include concerning behaviors, positive behaviors, suicidal and homicidal behaviors, and their status. Staff were strongly encouraged to put as much detail as possible concerning safety issues. Responsible party Residential Coordinator and Lead QP. Pass-a-longs started being uploaded into the Team Drive so all designated managers have access to them. Responsible party Residential Coordinator and Lead QP. 7/23/2019: Individual supervision was conducted with Lead QP, lack of documentation on the Pass-a-long was addressed and what future expectation of staff and Lead are to be put on the Pass-a-long going forward.	

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V 109	Continued From page 10 attained compliance with program rules on 3 shifts in the 15-day period. -The Pass Along Notebook was often not completed with details of any events/behaviors beyond noting the client's treatment status via abbreviations: OOO (Out of order), RO (restoring Order) or IO (In order). The lack of details made it difficult to utilize this resource as an effective way to track client behavior/progress/needs from day to day or from shift to shift as was the intent of this staff communication tool. Review on 7/12/19 of group supervision minutes from 5/28/19-6/27/19 revealed: -Meeting notes for 6/12/19 did not note the impending 6/14/19 admission of Client #2 or any individualized treatment/safety needs for Client #2 noted in his CCA and Crisis Plan. -For two weeks leading up to the decision to place Client #1 with Client #2 in a shared room, Client #1 was reported as having Concerning Behaviors such as "wrong time-wrong-place" behaviors, defined as masturbation in a non-private place, as well as aggressive behaviors, disrespect, lying, manipulating and keeping secrets. -After the 6/16/19 incident, the meeting notes on 6/19/19 did not indicate Client #1's treatment needs were discussed or that any additional safety measures were put into place while he remained in the facility. -Client #2 was staffed for the first time on 6/19/19 and documented has having "Offense Specific (OS) behaviors, lying, pushing boundaries, claims he doesn't know expectations when he has been presented with the expectations." He was reported to have "just arrived Friday" and the only treatment recommendations noted as "continue to call out lies and behaviors." No additional safety	V 109	7/23/2019: It was mandated to the therapist that she must be present either in person or via phone during staff meetings in order to staff all client cases and any specific high risk behaviors i.e. sexualized, suicidal, homicidal, etc. Weekly staff minutes are available upon request. The QP reported that frequently that she and the therapist staffed the client cases over the phone and she was also present on the phone during many staff meetings, however, minutes did not reflect this. Lead QP and Therapist now know to ensure their documentation reflects all contact between the two of them. 7/23/2019: The Residential Coordinator met with the Lead QP and the proper documentation of the group supervision minutes was discussed during supervision.	

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V 109	Continued From page 11 measures were reported. -The 5/28/19 meeting included staffing notes for all 7 residents of the facility and reflected attendance by overnight Staff #4 and Staff #5. Meeting notes for the remaining following dates reflected case staffings of only two facility clients per week on 6/5/19, 6/12/19, 6/19/19 and 6/27/19. -6/12/19 Meeting notes reported that a "group text starting for all shifts-it's been a great tool for communicating between shifts." -The LP was not documented as present or on a conference call with staff during the 5 weeks of meeting minutes provided to indicate clinical oversight in treatment planning and recommendations. Interview on 7/9/19 with Staff #4 revealed: -Date of hire: 2/4/19 -Worked overnight shift 11PM-9AM weekdays or 9PM to 9AM weekends -Staff#4 received no clinical/treatment information prior to the admission of Client #2 beyond being given the client's name. -Staff#4 reported Staff Meeting notes report on every client's treatment needs and recommendations every week. -Staff #4 reported Client #2's treatment needs may have been reviewed at a staff meeting that overnight staff was not required to attend. Overnight staff are required to attend every other staff meeting. -Staff #4 reported an example that in staff meetings, the QP might say "____is doing his disclosures so look for behaviors." -Staff #4 had not been informed that Client #1 was experiencing an increase in sexualized behaviors due to being in the Disclosure phase of treatment. -Staff #4 reported he was not aware of any clients	V 109		

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V 109	Continued From page 12 in the house having increased sexualized behaviors at the time of the incident on 6/16/19, noting no incidents had occurred overnight since February 2019. -Staff# 4 reported the QP makes decisions on which clients will share a room. Three clients had single rooms when the new client was admitted 6/14/19. -After the 6/16/19 incident, no client specific treatment recommendations and/or safety plans (beyond a room change) were reviewed with staff by the QP. -Regarding supervision of clients, Staff# 4 reported alternating walk throughs of the two hallways every 3-7 minutes with no more than 7 minutes between bed checks prior to the 6/16/19 incident. On the night of the incident, staff #4 did a walk of the hallway with Client #1 and Client #2 and then Staff #5 did a walk through 6-7 minutes later and found the clients engage in sexual activity. Interview on 7/9/19 with Staff #5 revealed: -Date of hire: May 2019 -Worked overnight shift 11PM-9AM weekdays or 9PM to 9AM weekends -Staff# 5 received no clinical/treatment information prior to the admission of Client #2 beyond being given the date of Client #2's arrival. -Staff# 5 had not been informed that Client #1 was experiencing increased sexualized behaviors due to being in the disclosure phase of treatment. -Regarding supervision of clients, Staff# 5 reports alternating walk throughs of the two hallways every 5-7 minutes with no more than 7 minutes between bed checks prior to the 6/16/19 incident. -On 6/16/19 at around 9:45pm, she caught Client #1 in the bed with Client #2. Staff #4 had already done a couple of checks prior to Staff #5 walking the hallway. When she asked Client #1 what he	V 109	8/1/2019: Updated the client safety plan/contract to include settle time and bedtime expectations. Prior to any clients being assigned to joint rooms a comprehensive safety plan must be completed and reviewed by all staff via pass-a-long, email, or staff office bulletin board. Lead QP is responsible to implement. 8/1/2019: Also updated peer restriction contract to include bedroom reassignment must take place if there are grooming behaviors between peers that share rooms. Both clients must have a peers restriction contract and safety plan. Lead QP is responsible to implement. Effective July 31, 2019 and prior to getting any new clients, the Residential Coordinator, now sends a complete behavioral summary to the Lead QP and Therapist, outlining high risk behaviors, triggers, signs and symptoms, etc. so Lead QP can present new case during weekly staff meetings prior to admission. Lead QP is responsible to ensure staff have the information necessary to provide safe and exceptional supervision of all clients served.	

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V 109	Continued From page 13 was doing, he jumped from the bed with no pants or underwear on and ran to his bed. Client #2 just rolled over and said nothing. Some staff from 2nd shift were still there. The clients were separated and each wrote a statement of what happened. -After the 6/16/19 incident, no client specific treatment recommendations and/or safety plans (beyond a room change) were reviewed with staff by the Lead QP. Interview on 7/16/19 with LP revealed: -The LP had not attended a staff meeting in person or on the phone for two months to discuss clinical information. -The LP gave client-specific clinical information to the Lead QP weekly, but she was not sure how the Lead QP documented this. -It was the LP's understanding that the Lead QP shares the clinical information/treatment recommendations with staff via email, the communication log or verbally. -The LP talked to the Lead QP by phone weekly, but the Lead QP was supervised by the Program Director (Registered Nurse). -The LP was not aware she needed to be providing supervision to the QP or documenting supervision with the QP. -LP recommendations made for Client #1 during May-June 2019: --look at medications as a possible factor in continuous erections, get a physical and do bloodwork. --Staff should encourage Client #1 to open up, use his Mindfulness Skills (happy thoughts and review worksheet with specific skills he has), allow him to talk about his dreams in the AM (process and connect with staff so he has a positive start to the day), practice coping skills, leave the bedroom to go to the bathroom at night,	V 109		

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V 109	Continued From page 14 redirect him to his fantasy log, and staff should be redirecting him to use his coping skills worksheet in treatment log that has exercises. -When LP did a coping skills group in the evening at the facility, the LP provided staff with skill sheets so they could help support the clients in learning/practicing skills from the group thought the week. -The LP was consulted on Client #1 being placed in a shared room with Client #2. The LP thought it was a good decision and didn't see any issues as Client #1 seemed to be managing his safety and was talking openly about it. Client #1 was doing "exceptional" in therapy. -The LP reported staff were to be doing constant checking of rooms. They did frequent checks every 5 minutes, then they did 5-10 minutes between checks, but they mix it up all night so that the clients cannot time the checks to know when to expect one. -After the incident in November 2018, the LP reported staff were to institute frequent, sporadic bed checks with an example being "one-minute staff walks the hall, then another staff walks the same hall a minute later." Interview on 7/9/19 and 7/16/19 with the Lead QP revealed: -The Lead QP made the final decision to place Client #1 and Client #2 in a shared room. She consulted the LP and Program Director. The QP did not document her phone calls/consultations with the LP. -The Lead QP was aware that Client #1 was in the disclosure phase of his treatment, which she stated typically has an increase in masturbation/sexualized thoughts and/or behavior. When asked Client #1 had a safety plan to reflect how staff should address these potential issues, she stated nothing was written down	V 109		

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V 109	Continued From page 15 about this and Client #1 could sleep on the couch if he had sexual urges at night. -The Lead QP did not consider holding off on admitting Client #2 due to the inability to give him a single room at the time of his admission. She has never requested the admissions committee to hold off on admitting a new client due to the milieu needs of the facility at the time of a new admission. -The Lead QP did not consider that Former Client (FC) # 8 was scheduled for discharge on 6/20/19 and waiting six days to admit Client #2 would have allowed him a single room upon admission. -Normally newly admitted clients get their own room for the first 30 days, but this was not possible for Client #2's admission to the facility. The facility already had "two aggressors" in single rooms with whom the Lead QP noted it would not have been appropriate to put a new client. - Client #1 was chosen to share a room with Client #2 as Client #1 had not shown any behaviors since his last incident with FC #8 in November 2018. -The Lead QP was aware that Client #1 had previously engaged in sexual behavior when in a shared room with FC #8. - Client #1 was reported to have been making progress since December 2018. -Client # 2 was coming from Therapeutic Foster Care (TFC) and it was reported he was known to be "more vulnerable" as he had never been in a facility. The Lead QP reported FC #8 had also come from a home environment and was new to the facility when the incident occurred with Client #1 in a shared bedroom in November 2018. -The Lead QP reported she did not think Client #1 would struggle with a roommate again. Client #1 was asked by Lead QP if he could handle a roommate and Client #1 stated it was fine. -The lead QP reported Client #1 was "the best	V 109		

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V 109	Continued From page 16 option at the time" due to the other high-risk sexual behaviors already being exhibited in the house by other clients who required single occupancy rooms. -Regarding the dissemination of clinical information/treatment recommendations discussed with the LP, the Lead QP reported she shares this information by email. She was not sure if she shared any clinical information about Client #2 prior to his admission. She reported staff can to go into their electronic medical record to see all of Client #2's information, but they don't always have time to do that. No emails were provided to Surveyors after various requests for any documentation showing the dissemination of clinical information to direct care staff. -The Lead QP had never heard of the LP's specific recommendations for Client #1's treatment to include: Staff should encourage Client #1 to open up, use his Mindfulness Skills (happy thoughts and review worksheet with specific skills he has), allow him to talk about his dreams in the AM (process and connect with staff so he has a positive start to the day), practice coping skills, leave the bedroom to go to the bathroom at night, redirect him to his fantasy log, and staff should be redirecting him to use his coping skills worksheet in treatment log that has exercises. -The only treatment recommendation she made for staff regarding the admission of Client #2 to the facility was to do more frequent bed checks on both day/night shifts. -The Lead QP could not remember if she discussed Client #2's specific treatment needs or safety issues with the LP or the staff prior to his admission on 6/14/19. Regarding the Lead QP's supervision of paraprofessional/direct care staff, the Lead QP	V 109		

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V 109	Continued From page 17 reported that as of 6/17/19, "Clients are constantly observed" as staff began sitting in chairs positioned in each of the two hallways. They no longer document walk throughs of the hallways because they are continually monitoring clients. -During shift change, "as soon as staff come on deck, they are to do bed checks." Shift change was at 9PM on weekends and 11PM on weekdays. Staff could no longer sit at the dining room table during shift change. Day staff sat in the hallways until the overnight staff relieve them. -The Lead QP reported the overnight staff can pace the hallways if one of the two staff must take a break and/or attend to a nightly chore list consisting of 19 items staff complete each shift. If there was only one staff on the main floor, the default location is for the staff to be on the back hallway where the shared bedrooms are located. -Prior to 6/16/19 incident, staff were walking the hallways doing bed checks. The day shift staff did bed/room checks every 7-12 minutes and the overnight staff did bed checks every 5-15 minutes. On weekdays, staff sat in the observation chairs in the hallways from 10:00pm-10:30pm only. On weekends, staff sat in the hallways until 9PM. The staff kept a log documenting the times they walked the hallways to do bed checks and the log noted the status of the clients when staff observed them (asleep, awake, etc.). -The Lead QP ensured staff were doing bed checks by intermittently watching the live cameras in the house on her phone at night or calling the staff to ensure they were awake. There was no schedule/procedure for when/how often to monitor the cameras to ensure appropriate staff supervision was occurring. -When asked the last time the Lead QP watched camera footage, she stated: "2-3 days ago ...I	V 109	Beginning 7/23/2019, a new Camera Log was developed and dispersed to the Program Director, QI Director, Residential Coordinator, and Lead QP. All above named staff are assigned responsibility to randomly review the live camera footage for different times, days and shifts and log what they viewed while watching the cameras. Logs available upon request.	

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V 109	Continued From page 18 haven't been doing it recently, staff don't do walks anymore, so I don't need to time them, I see them get up every 5-7 minutes." -The Lead QP had not watched any recorded video of staff since the incident on 6/16/19. -The Lead QP reported she watch recorded video of the 6/16/19 incident from 8:30PM until the incident occurred at 9:45PM. She reported the day shift was "not doing bed checks, basically didn't do it at all, it was chaotic, they weren't sitting in the halls at all." The Lead QP had no concerns regarding the night shift on 6/16/19. The Lead QP did not watch video footage after the 9:45PM incident occurred to ensure the overnight staff were appropriately supervising. Regarding what safety measures were put in place after the 6/16/19 incident, the Lead QP reported: -The day/night staff now sat in the hallways (one staff sits in each of the two hallways). -From 2-11pm, a 3rd staff member sat and watched the cameras. -Partitions were placed in the shared rooms. -The facility added 5-6 more cameras. -The Lead QP reported they have motion lights that they ordered, but these have not been installed yet due to the maintenance man being on vacation. The Lead QP presented an Amazon Order receipt for review noting motion cameras were ordered 6/25/19 (the facility previously reported they ordered motion lights for the bedrooms/hallways after the first incident with Client #1 in November 2018). -The Lead QP reported they did not install cameras in the double bed rooms due to client rights issues. -There were now 24 total cameras. There was no schedule/process for monitoring either live cameras or recorded videos.	V 109	The November 2018 motion lights were installed in hallways and all bedrooms but they were night lights that plugged into the wall and were not bright enough to get adequate view. 6/24/2019: Motion Ceiling Lights were ordered 6/26/2019: They arrived on at the Main Office 7/19/2019: Lights were installed, it was identified as a problem due to the maintenance personal not installing them in a timely manner, this has been addressed with the Lead QP and maintenance.	

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V 109	Continued From page 19 Interview on 7/16/19 with the Program Director (PD) revealed: -The PD completed the intake for new Clients and determined which house the new client would work best in. She asks the Lead QP what room to place the new client in. -The PD told the Lead QP to place Client #2 in a single room and the Lead QP stated this was not possible as she already had two clients in single rooms. -When the PD brought Client #2's belongings over to the facility, she was informed of the Lead QP's decision to place Client #2 with Client #1 in a shared room. The PD told the Lead QP "This isn't going to work." - The PD told the Lead QP to talk to the LP and redo room assignments. The PD meant to follow back up with the Lead QP to check on room assignments but did not do so. The PD was unsure if the Lead QP spoke with the LP regarding room assignments after she told the Lead QP to redo them. - The PD noted the Lead QP could have recommended holding off on the admission but noted that perhaps the Lead QP did not feel she could make this recommendation as she as still new to her House Manager role. -The PD noted there was no team discussion to increase staff on the overnight shift to accommodate the increasing supervision needs of the facility. She reported they keep staff at the ratio they are required to. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 violation and must be corrected within 23 days.	V 109	On 7/23/2019, company established policy and procedure written criteria for Residential Level III sex offender home room placement. This procedure outlines how all youth high risk and new admissions will be housed within the facility. It covers single occupancy rooms, double occupancy rooms, how to select which clients may share rooms, emphasizes importance of staff supervision and direct line of sight. Further more, this procedure also addresses expectations for staff during shift changes and if no viable rooms are available to ensure safety. See attached policy. Policy # 7-007 Supervision Protocol and Room Assignment for 24 hour surveillance. Lead QP and Residential Coordinator, and Therapist are responsible for room assignments.	

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V 111	Continued From page 20	V 111		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement strategies prior	V 111		

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V 111	Continued From page 21 to the delivery of services to address the client's presenting problem for 1 of 3 audited clients (Client #2). The findings are: Record review on 7/9/19 for Client #2 revealed: Date of admission: 6/14/19 CCA (Comprehensive Clinical Assessment) recommendations: The CCA dated 5/30/19 reports Client #2 is" highly opportunistic, and it is recommended that he not be left unsupervised due to history of theft and sexually harmful behaviors to others." Crisis Plan updated 6/6/19 prior to admission into the facility reports an environmental trigger of "unfamiliar social settings" and an interpersonal trigger noting "history of attachment issues and does not do adjust well to change." Person Centered Plan (PCP) Goals on 6/6/19: -Stay out of trouble aeb (as evidenced by): explore how impulsiveness results in poor decision making and unsafe/harmful behaviors, zero incidents of sexually inappropriate behaviors, process inappropriate behaviors, use problems solving skills and safety planning for high risk activities before they occur, be accountable for and accept consequences for behaviors, accepts limits, follow rules, -Maintain appropriate behaviors with others aeb: refraining from engaging in/encouraging peer negativity (breaking rules, instigating drama, arguing), being respectful, learn/practicing conflict resolution, use healthy communication, eliminate physical aggression, reduce verbal aggression, apologize to others, engage in healthy recreation, practice appropriate boundaries, talk about how behaviors affect others in group. Interview on 7/9/19 with Lead Qualified Professional (QP) revealed: -The only treatment strategy shared verbally with	V 111	Per the Plan of Protection this has been addressed on 7/23/2019 in individual supervision with the Lead QP and Licensed Professional in a group meeting on the same day at 4pm. Completed by the Residential Coordinator. Quote: " Licensed Professional will be responsible for CCA addendum as significant changes occur in client behaviors and/or high risk behaviors. At minimum Licensed Professional shall addend all CCAs every 6 months. Likewise, when addendum are completed changes may be to be made to the PCP and CCP.	

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V 111	Continued From page 22 staff to address the specific treatment needs of Client #2 prior to the delivery of services was to do more frequent bed checks on both day/night shifts. -No information about Client #2 was reviewed in the staff meeting on 6/12/19 prior to the client's admission to the facility. -No additional supervision plans/strategies or additional staff were discussed/added to help monitor Client #2's placement into a shared room. -The Lead QP cannot remember if she discussed Client #2's specific treatment needs or safety issues with the LP or the staff prior to his admission on 6/14/19. -The Lead QP noted it was her responsibility to update treatment plans monthly and that was done at monthly Child and Family Team Meetings (CFTs). This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 violation and must be corrected within 23 days.	V 111	Effective July 31, 2019 and prior to getting any new clients, the Residential Coordinator, now sends a complete behavioral summary to the Lead QP and Therapist, outlining high risk behaviors, triggers, signs and symptoms, etc. so Lead QP can present new case during weekly staff meetings prior to admission. Lead QP is responsible to ensure staff have the information necessary to provide safe and exceptional supervision of all clients served.	
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies;	V 112		

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V 112	Continued From page 23 (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to update strategies to address the behaviors effecting 1 of 3 clients (Client #1). The findings are: Record review on 7/9/19 for Client #1 revealed: Admission Date: 8/23/18 Discharge Date: 6/24/19 -12/20/18 treatment plan included the following goals: --Goals to not tie and manipulate others, stop all inappropriate behavior (related to offense specific behaviors,) and to work on building positive relationships with peers/adults --12/20/18 Crisis Plan noted on situations that have caused trouble in the past as "Client participated in inappropriate sexualized behaviors with his roommate while at the group home and kept it a secret from staff until the other peer involved admitted to it." Crisis plan noted Client # 1 does not like to be told No, does not like to discuss his family and that he "likes to fight."	V 112	On 7/23/2019 at 4pm the Residential Coordinator called a meeting with all Residential Therapist, Residential Clinical Director, all Residential Lead QPs and the Program Director. In this meeting it was outlined the following: Licensed Professional will attend all staff meetings either via phone or in person to staff high risk cases and safety planning, Licensed Professional will clinically supervise the Lead QP and reflect this on her LP logs, Licensed Professional is also sending out weekly updates to the Lead QP about each client via email.	

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V 112	Continued From page 24 -No new goals/strategies/interventions had been added to the plan since it's effective date of 1/9/19. -The plan gave updates monthly on Progress Towards Goals section, but no new strategies or interventions are reported in this section to address the needs outlined in the monthly updates. -Prior to the 6/16/19 incident, the treatment plan "Progress on Goals" section dated 5/17/19 reported: "[Client #1] has been struggling with aggressive behaviors and threats towards peers since his last CFT. [Client #1] struggles with making aggressive comments towards his peers when he gets upset. [Client #1] has worked on his visual boundaries since his last CFT and continues to make progress. [Client #1] continues to blame-shift his behaviors onto staff and his peers instead of taking accountability for his own actions. [Client #1] still struggles with keeping secrets. [Client #1] connects with staff and states he feels like he is hiding something but doesn't now what. [Client #1] struggles with accepting feedback from his peers and certain staff. [Client #1] continues to have thinking errors and distortions but is currently working with the therapist to process them. [Client #1] continues to work on relationships that he has broken due to his aggressive behaviors." -After the 6/16/19 incident, the treatment plan "Progress on Goals" section dated 6/21/19 reported: "[Client #1] continues to struggle with his attitude and behaviors since the last CFT. [Client #1] struggled with keeping secrets around his behaviors and boundaries with his peers and staff. struggles with keeping secrets has engaged in sexual behaviors within the group home with another peer who claims the behavior was not consensual. [Client #1] has been accountable for his behaviors but struggles with accepting	V 112		

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V 112	Continued From page 25 feedback from staff around them. [Client #1] connects with staff when he is upset but justifies his behaviors and tries to blame shift them on "being on his cycle" and "being stressed." [Client #1] continues to have thinking errors and distortions but is currently working with the therapist to process them. [Client #1] struggles with using heathy humor and when are the appropriate times he can use humor." Record review on 7/9/19 of Licensed Practitioner (LP)'s progress notes for Client #1 from 4/16/19-6/18/19 revealed: -4/16/19 Progress note: Client #1 was open about how he has been staying highly sexual recently. -4/19/19 Progress note: Client #1 went over his disclosures with the therapist. -4/23/19 Progress note: Client #1 worked on impact essay. -4/30/19 Progress note: Client #1 feels he cannot get his mind off masturbating. -5/14/19 Progress note: Client #1 continues to have difficulty with consistently having erections. Completed letter to victim. -5/21/19 Progress note: Client #1 continues to have urges at night and is having wrong time-wrong place. -5/25/19 Progress note: Client #1 admitted how he has been doing wrong time-wrong place. He continues to have extreme issues with controlling his sexualized urges. He tends not to use his coping skills at times. - 5/30/19 Progress note: Client #1 continues to do wrong time-wrong place due to his feeling he cannot control his urges. -6/6/19 Progress note: Client #1 continues to have sexualized thoughts and he explained someone has seen him masturbating. -6/8/19 Progress note: Client #1 stated he continues to have issues with constant erections	V 112		

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V 112	Continued From page 26 and is unsure what to do about them. 6/9/19 Last Progress note: therapist supported Client #1 going over his disclosures to a family member. Interview on 7/16/19 with LP revealed: -LP made specific treatment recommendations for Client #1 during May-June 2019 as follows: --look at medications as a possible factor in continuous erections, get a physical and do bloodwork. --Staff should encourage Client #1 to open up, use his Mindfulness Skills (happy thoughts and review worksheet with specific skills he has), allow him to talk about his dreams in the AM (process and connect with staff so he has a positive start to the day), practice coping skills, leave the bedroom to go to the bathroom at night, redirect him to his fantasy log, and staff should be redirecting him to use his coping skills worksheet in treatment log that has exercises. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 violation and must be corrected within 23 days.	V 112	Licensed Professional is now required to provided weekly updates via email to the Lead QP about the client's behaviors, current status in therapy, and any other viable information the staff would need to know. The Lead QP is responsible for reviewing this information and forwarding it to all of her direct care staff. Residential Coordinator will monitor all emails and uploads to ensure that it is being sent.	
V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of	V 293		

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V 293	Continued From page 27 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 28 This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure individualized supervision to minimize the occurrence of behaviors related to functional deficits of 4 of 7 Clients (Client #1, #2, #5 and #7). The findings are: Cross Reference: 10A NCAC 27G.0201 Governing Body Policies (V105) Based on record reviews and interviews, the facility failed to develop and implement written policies for admission based on current census, acuity and ability to meet the individual needs for 1 of 7 clients (Client #1). Cross Reference: 10A NCAC 27G.0203 Competencies of Qualified Professionals and Associate Professionals (V109). Based on record reviews and interviews 1 of 1 Qualified Professionals (Lead QP) failed to demonstrate knowledge, skills and abilities required by the population served by failure to have effective safety measures in place for new resident and failure to ensure client specific training was provided to all staff. Cross Reference: 10A NCAC 27G.0205(a) Assessment and Treatment/Habilitation or Service Plan (V111). Based on interview and record review, the facility failed to develop and implement strategies prior to the delivery of services to address the client's presenting problem for 1 of 3 audited clients (Client #2). Cross Reference: 10A NCAC 27G.0205(c) Assessment and Treatment/Habilitation or	V 293	Policy #7-007 protocol for direct line of sight supervision was updated. Residential Coordinator updated on 7/23/2019.	

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V 293	Continued From page 29 Service Plan (V112). Based on record review and interviews the facility failed to update strategies to address the behaviors effecting 1 of 3 audited clients (Client #1). Cross Reference: 10A NCAC 27G.1705 Requirements for Licensed Practitioners (V297). Based on record reviews and interviews, the facility failed to provide face to face clinical consultation with Qualified Professional (QP) by a Licensed Professional (LP) during her 4 hours per week in the facility. Record review on 7/10/19 for Client #1 revealed: Admission Date: 08/23/18 Age: 14 Transferred to detention 6/24/19 as a result of 6/14/19 incident. Diagnoses: Conduct Disorder, Attention Deficit Hyperactivity Disorder (ADHD) combined type, Generalized Anxiety Disorder (GAD), Tourette's Syndrome, Perpetrator of non-parental sex abuse of a child. Record review on 7/10/19 for Client #2 revealed: Date of admission: 6/14/19 Age: 16 Diagnoses: Conduct Disorder, Attention Deficit Disorder. Record review on 7/10/19 for Client #5 revealed: Date of Admission: 9/20/19 Age: 15 Diagnoses: Conduct Disorder, Other unspecified Trauma and Stress Related Disorder. Record review on 7/10/19 for Client #7 revealed: Date of Admission: 11/30/18 Age: 14 Diagnoses: Oppositional Defiance Disorder,	V 293		

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V 293	Continued From page 30 Conduct Disorder, Major Depression and Tobacco Use Disorder. Review on 7/10/19 of individual Client statements regarding the incident on 6/16/19 revealed: Client #1's statement revealed: "It all started I was masturbating and he saw me and he asked me to masturbate him. I said ok so then he said let me suck your penis so I let him and I put my hand on his head and then I ask if he wanted to have oral sex and he said yea so I bent over he put his penis in my butt. Then you started humping me and so I said yes daddy to him and then he cummed in me and then I turn around and I started to masturbate him. I said you already cummed he said yea then he fell asleep then I was still hard so I took off my shorts and humped his face. I did it multiple times." Client #2 statement revealed: "Yesterday we were going to bed and I seen [Client #1] playing with his penis while we were supposed to be going to bed. Today [Client #1] was trying to get me to engage in his negative behaviors. First he said that he was going to act out, 'you have never seen me act out'. [Client #1] then was masturbating on his bed and I told him to stop a couple of times. He didn't so I pretended to be asleep while doing that [Client #1] was poking and whispering my name. After that didn't work he started to get up multiple times out of his bed. [Client #1] without my consent in the first place was putting his penis and genitals in my face, while putting his mouth over my penis and stroking it. I said no multiple times and he did it over and over. Before a staff noticed what he was doing he ejaculated on my nose and cheek. I wiped it off then staff came in the room." Client #3 statement revealed: "Last night we got done with status at about 8:45pm. Well I went to my room and layed in my bed. About 10-15 mins	V 293		

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V 293	Continued From page 31 later which was 8:45-9pm I saw [Client #1] get up out of bed and walk to [Client #2]'s side of the room. Well [Staff #4] started down the hall and [Client #1] quickly ran to his bed. He was laying with his head towards the door. [Client #1] got back up and went to [Client #2]'s side of the room and [Client #6] then asked to step in to go to the bathroom. [Client #1] did he same thing he ran back to his bed. He was also looking at me when this was happening. [Staff #4] came to check the rooms. Then I was like half asleep and the next thing I remember was [Staff #2], [Staff #5] and [Staff #4] came to his door and [Staff #2] went into his room and told him to get up and go to the milieu. I recall [Staff #5] saying [Client #1] didn't have his pants on. Then [Staff #8] came. [Client #1] told him not to talk to him. Then [Client #1] went outside. Then like 15-20 mins later [Client #1] came back in and said he wanted his shoes and that he wanted to run. [Staff #8] said to [Client #1] that there are two paths-one you act out and get into trouble or you don't and you might or might not get into trouble. He also said he supported the side that keeps you out of trouble and [Client #1] said that he was going to choose [Staff #8]'s side to keep you out of trouble ..." Review on 7/10/19 of internal review summary dated 6/19/19 and signed by QI (Quality Improvement) Director revealed: -"Incident Summary-On 6/16/19 at approximately 9:45pm, [Staff #5] was conducting a bed check and observed [Client #1] in [Client #2]'s bed on top of [Client #2] under the covers. [Staff #5] asked [Client #1] what he was doing at which time [Client #1] jumped from the bed and ran across the room. [Staff #5] stated that she saw the [Client #1] did not have any pants or undergarments on. [Staff #5] told [Client #1] to	V 293		

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V 293	Continued From page 32 step out of the room into the milieu. [Client #1] started yelling to [Staff #4] that [Staff #5] was a liar. [Client #1] then went outside and started punching the house. Supervisor was immediately contacted and statements were written from both consumers as well as the staff that monitored and observed them ... " -"Review Summary-Leading up to the incident, there was a 30 minute period of time that staff did not routinely monitor the hallways while the consumers were in their bedrooms. After reviewing camera footage, it was apparent that consumers had the opportunity to engage in these behaviors due to the lack of supervision. Staff violated agency polies AEB [as evidenced by] not routinely maintaining line of sight during sleeping hours. Shift lead interviewed each client the night of the incident. Residential House Lead [Lead QP] called the local police department and DSS (Department of Social Services) on 6/17/19. Deputies came out to the house, read the statements and gathered information on the consumers and staff. Deputies indicated they would return later that afternoon so set up an interview with each consumer. Clinical Director, Program Director, Clinical Coordinator and Residential House Therapist were informed of the incident on 6/16/19. QI (Quality Improvement) Director was informed on 6/17/19. Staff separated both consumers and provided alternative sleeping arrangements; one consumer slept in the original bedroom and the other on the milieu couch. House Lead and QI reviewed camera footage on 6/18/19. Residential House Therapist interviewed each client on 6/18/19." -"Corrective Action-Responsible staff will be written up. House Manager [Lead QP] contacted each overnight staff to maintain supervision throughout the entire evening on 6/17/19. House Manager [Lead QP] will review expectations	V 293	6/25/2019: Two staff was given final disciplinary actions around supervision of clients during client sleep hours. Responsible party is the Lead QP.	

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V 293	Continued From page 33 again during the next house staff meeting on 6/27/19. Agency will buy room separators and light sensors to discourage consumers from engaging in inappropriate sexual behaviors." -Written Disciplinary Notice was given to Staff #1 and Staff #3 on 6/19/19 for failing "to supervise clients [on 6/16/19] in the hallways after they had went to bed and also no bed checks were conducted after the clients went to bed until the next shift arrived." Review on 7/9/19 of "Overnight Sleep Watch" log for 6/16/19 as recorded by Staff #4 and Staff #5 revealed: 9:07- [Client #1] and [Client #6] awake. All others asleep. 9:11- [Client #1] and [Client #6] awake. All others asleep. 9:18- [Client #1] and [Client #6] awake. All others asleep. 9:25- [Client #6] bathroom. All others asleep. 9:34- All Clients asleep. 9:45- All Clients asleep. 9:55- [Client #1] and [Client #2] awake. All others asleep. 10:00- [Client #1] [Client #2] and [Client #5] awake. All others asleep. Review on 7/10/19 of Level I Incident dated 6/15/19 (Saturday) at 11pm revealed: -Incident involved Client #5 and Client #7 sexual behavior not involving law enforcement. The incident was self-disclosed by Client #5. -Client #5 wrote a statement on 6/18/19 regarding the incident. "It was about 15 min after I got done using my crisis plan. I got done correcting with [Staff #6] and I went to my room. [Client #7] said something and I flipped him off and he did it back to me. We continued to do this then I got an erection and started to masturbate. [Client #7]	V 293		

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V 293	Continued From page 34 then asked what I was doing. I told him I was masturbating. I asked him if he wanted to help. He said how will that work. I stated that I would walk over there and he could jack me off. He then said ok. Then said you can use your mouth if you want to. He said ok and started to use his mouth. Staff started to come back there so I rushed to my bed and acted like I was asleep. After they did checks we both got up and he got on his knees and started to do it again. I believe that staff heard something so they came back to check. We got back in bed and waited for them to go away. I then got up and walked over to his bed and he started ...". The remaining few sentences of this statement were not legible. -Client #7 wrote a statement on 6/18/19 regarding the incident. "Me and another client was in the same room together. He kept flipping me off. He was doing wrong time wrong place [masturbating] and he asked me if I would help him ejaculate. I said sure I would help and later he came to my bed and put his penis in my mouth and he came in my mouth and I swallowed some of it and he laughed and said I'll do you tomorrow night/Sunday." Review on 716/19 of Incident Response Improvement System (IRIS) report dated 7/9/19 revealed: "At approximately 8:00PM on 7-08-19 Staff prompted [Client #7] to participate during status group, staff told Client that if he had unneeded comments or triggering peers he would get not participating during status. [Client #7] had unneeded comments and triggering peers by telling his peers to shut up and calling them ugly. [Client #7] got up and walked to his bedroom. Staff went to his bedroom and asked him to come out so staff could see him. [Client #7] went into the hallway and threw the soap in the floor, ripped	V 293	We recognize that this should not have occurred, but even in the best facilities clients continually look for ways to work around monitoring, rules, and regulations. Staff were monitoring the hallways and rooms as directed. We do feel like the added petitions, motion detectors lights in each shared room and staff sitting in the halls until 3am will ameliorate sexual encounters between clients.	

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V 293	Continued From page 35 the bathroom sheets up, and broke a pen. [Client #7] tried to get more of the bathroom sheets to rip up but staff went into the hallway and took them from [Client #7]. [Client #7] came out of the hallway and got his bedtime snack and then went back into his bedroom and did not check anything out. The rest of the clients would not go to bed because [Client #7] was causing so much chaos in the house. Staff had to convince the other clients that [Client #7] was not going to do anything to them and for them to go to bed. Staff sat back in the back hallway and asked [Client #7] if his behaviors were around keeping secrets with the water being turned off. [Client #7] got upset and started arguing and started blame shifting and telling the staff all the other concerns that other clients had. Staff asked if the other client's actions were the reason he was acting out. [Client #2] asked Client to be quiet so the other peers could go to bed. [Client #7] said [Client #2] could plug his ears up and not listen to him. [Client #2] said another comment and that's when [Client #7] came out of his bedroom and said he did not have to take this s**t anymore. [Client #7] walked past the table in the hallway and slung the bathroom sheets and the clock to where it almost hit a staff in the head and it went into other client's room. [Client #7] walked in to the milieu area past the kitchen table and staff went to grab the chair before [Client #7] did but staff did not get to it in time. [Client #7] slung the chair into the kitchen and hit the oven and shattered the ovens glass front. [Client #7] went outside and waited for the police to arrive. [Client #7] talked to a staff while he was waiting. [Client #7] walked inside to get water and go to the bathroom and when he saw what he had done to the oven he smiled and said d**n I did a good job. Police arrived and [Client #7] talked to them. As police left [Client #7] smiled and laughed and staff	V 293		

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V 293	Continued From page 36 asked if he thought it was funny. [Client #7] went back into his room and laid down. Staff called [Client #7]'s mom to report what the police said and she asked to talk to [Client #7]. [Client #7] came out of his room and talked to his mom on the front porch, staff prompted Client more than once to get off the phone and go to bed. It took staff intervening and telling his mom that things had to be done and [Client #7] had to go back to bed. [Client #7] got off the phone with his mom and went back to bed." Review on 7/16/19 of video footage of 7/15/19 from 11pm-11:09pm revealed: **Technological difficulties/latency issues on the video made playback of any camera recording difficult. It took one hour to watch 9 minutes of video and the video disconnected repeatedly throughout the hour. -At 11PM, Staff #5 was reclined in the staff observation chair with her feet propped up on a second chair in front of her on the long hallway (3 bedrooms). She was covered up to her chin with her jacket. -At 11PM, Staff #4 was not on camera in the main level of the facility where the bedrooms are located, as he was in the basement of the facility. -No staff is walking the length of the main floor to monitor bedrooms on both hallways when Staff #4 is in the basement of the facility. -It is unclear how long Staff #4 had been in the basement prior to reappearing back on camera at 11:01PM or how long Staff #5 was reclined in the staff observation chair prior to 11PM, as the video replay prohibited rewinding past the 11PM search parameter time without completely disconnecting the video feed from the system. -At 11:01PM, Staff #4 enters through the basement door into the same hallway as Staff #5. He addresses Staff #5 who gets up from the staff	V 293		

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V 293	Continued From page 37 observation chair and brings her jacket/belongings the 2nd hallway. Staff #5 places her belongings on a desk by the staff observation chair and goes to the kitchen. -At 11:02PM, both staff are in the kitchen. -At 11:03, Staff #4 does a bed check/walkthrough of the long hallway on his way to sit in the staff observation chair on that hallway. He remains in the chair in the long hallway until the video ends at 11:09PM. -At 11:05, Staff #5 goes to the staff observation chair in the short hallway (2 bedrooms) and eats at the desk until the video ends at 11:09PM. She does not do a bed check on her way to the staff observation chair from the kitchen. -No staff does a bed check on the short hallway between 11:01 and 11:09PM. It is unclear if Staff #5 did a bed check on the short hallway between 11:01PM and 11:02PM, as the camera on the short hallway was unable to playback video during that timeframe (feed disconnected). Interview on 7/9/19 with Client #2 revealed: -He had been there about a month. He was now in a room alone. -Concerned about other clients screaming and cussing at staff and peers. -Last night Client #7 got angry and threw clock almost hitting staff then threw a chair into the stove. Cops came. Staff #3 was supposed to be sitting in the back hallway but walked down the hallway to write her notes. Client #3 then went into Client #7's room, threw sheets, blanket, pillow out the window and went back to his room to lay down. Client #7 was outside talking to cops- no staff were in hallway to see this happen. Staff #2 was in other hallway and Staff #1 was in living room. -Usually have to be in bed by 8pm then lights out. Up at 6:15am for day treatment at 8am.	V 293		

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V 293	Continued From page 38 -3-4 staff during the day; 2 staff at night. Staff #6 and Staff #7 don't take no crap. They used to walk the hallway every 5-6 mins but now 1 person had to sit in the hallways and they switched every hour. This changed about a week after he got there. -He didn't know if he felt safe or not. -Felt restrictions were overboard-7 mins in bathroom, can't listen to certain music, watch certain shows or say certain words-like "that sucks". Always being watched. Interview on 7/9/19 with Client #3 revealed: -He had been here 4 months since March 8th. -Staff made room changes in the last few weeks and the rules are tighter. Staff enforced the rules 100% of the time now. They may have been lenient before. -Staff sit in hallways every night now-they might rotate but I'm asleep so I don't know. They've been sitting in the hallways the last 3 weeks. -Staff used to walk the hallways every 5-10 minutes-it was a little effective but way too lenient. -Staff on the PM shift had no issues but the residents try to manipulate the new overnight shift staff (example: they talk their way out of trouble by getting staff to be concerned for them so they end up getting encouraged instead of held accountable) -"I know exactly what happened to bring you here to investigate" (Client proceeded to draw a diagram of where his room is in relation to where the incident occurred between Client #1 and Client #2). Client #3 reported a similar version of events as to those reported in IRIS. -There are 8 more cameras now but staff are not monitoring them most of the time but the cameras do record stuff. -"I do not feel safe there right now due to a peer	V 293		

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V 293	Continued From page 39 acting out. The peer is unsafe and staff can't stop the peer's behavior. Staff would have to restrain him and they don't." -"I am concerned about what happened last night. The peer got mad over name calling, so he threw a clock and threw over a table and busted the glass on the stove by throwing a chair into it. This happened at 9PM. Staff handled it OK but they got pretty mad." Interview on 7/9/19 with Client #4 revealed: -This was his second stay at this facility and was going well. -Shared a room with Client #3. -Last night, Client #7 had thinking distortions. Staff #3 was trying to redirect him. Staff #3 left the hallway and Client #3 went into Client #7's room and threw sheets/blanket out his window. -All 3 staff had to monitor last night. -Staff do checks every 10-15 minutes but he's usually asleep. -If staff had to leave a chair one of the clients in a shared room had to step out. -He took sleeping meds so he didn't see shift change often. -Sometimes he feels safe- when clients are throwing things or being loud he doesn't feel safe. -He would get migraines when it would get loud in the house which triggered his trauma. -He didn't really trust line staff to tell his problems to. They don't listen and don't get it right. Interview on 7/9/19 with Client #5 revealed: -He had been at the facility for ten months -He had noticed staff are more attentive since the incident, noting the focus was more on the clients and they are keeping them in eye sight at all times. -There were 3 staff during the day. There are 6 kids, so they are in 1 to 2 ratio.	V 293		

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V 293	Continued From page 40 -There were 2 overnight staff, one in each hallway. -Staff monitored us from the safe place (staff observation chairs). -Staff put up dividers for privacy. -Staff increased the amount of attention they pay clients-it's a lot of attention now. -Before the incident, staff sat at the dining room table and did checks every 15 minutes. Interview on 7/9/19 with Client #6 revealed: -He had been at the house since February 7th. -He reported "It's going alright but it's a bunch of chaos ..." -Staff have been stricter in the last few weeks-they call you out more than they used to. -"Staff now sit in the back hallways every night-I'm not sure if they ever get up as I'm asleep." -There were now dividers in the rooms with 2 beds. -Client # 7 threw a chair last night and broke the stove. -Staff was not monitoring us when they were cleaning up the mess from the stove. One staff said "don't do anything stupid" because they knew they couldn't watch us and clean up. When staff went to write in the "pass along book," a peer went into Client # 7's room and threw his stuff out the window without staff noticing. -The cops came for the stove incident-they said "don't misbehave again." -"There's a bunch of 14-17-year-olds here acting like 5-year-olds ...someone turned off the cold water in the bathroom so now none of us can go on outings until that peer confesses." -"They need more staff here, maybe getting one on Friday." The back-end shift (Thursday-Saturday) had more problems as that staff was newer and not as authoritative.	V 293		

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V 293	Continued From page 41 -They needed cameras in the bathrooms and bedrooms. -"New peers needed time to adjust-they try to give new kids single rooms, but not always. The last new peer came in and immediately began acting up. He turned the water off because he was mad at staff because they made him take his meds and he thought he couldn't be made to take his meds anymore if there was no water coming out of the sink. Now we are all on restriction until he confesses." Interview on 7/9/19 with Client #7 revealed: -He had been there since 9/30/18 about 8 months. -Around 9:30pm last night, Staff #3 was talking to him about his behaviors. The other clients kept commenting and told them to shut up. "I got mad." -"Peers just start crap and staff don't act like staff." -Staff #1 slammed doors and made smart comments to him which trigger him. "She had an intimidating tone." -3 staff work during the day and 2 staff at night. They sit in the hallways but not all the time. -"We have to always be within eye sight of staff." -There had not been any changes in supervision. Interview on 7/9/19 with Staff #1 revealed: -She worked 2-11PM as a Residential Counselor and has been there 1 year. -When clients were in their bedrooms, staff were constantly in the hallways at all times. -Staff limited rooms to 1 boy but if they can't, they put a divider in the room. -The Lead QP determined roommates. -The night shift looked into rooms every 5-7 minutes-they just stay in the chairs. -More cameras were installed after the incident.	V 293		

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V 293	Continued From page 42 The camera screen was in the office and staff were in there usually just to write notes. -Staff #1 had worked late on 6/16/19 and was still on-site when she heard Staff #5 say "What are you doing!" -Staff #1 called the Lead QP to report the incident and was told to separate the boys and get statements from them. The Lead QP called the Program Director. -The incident on 7/8/19 that involved Client #7 breaking the kitchen stove involved law enforcement. Client #7 left line of sight and when prompted to return, he came out of his room, ripped up a notebook, threw a clock, broke a pen, and was very defiant. "It was the most physical aggression I've seen in 7-8 months. He's not appropriate to be here. His behaviors interfere with being able to do OS treatment." -Staff got all the boys in the living room so they could monitor them. -Staff had asked why there is no 3rd staff person on the overnight shift-they think there should be a 3rd person. Interview on 7/9/19 with Staff #2 revealed: -She worked the 2-11pm shift and every other Sunday 9a-9p. She began in October 2018. -She was working on her notes the evening of the incident (6/16/19). Staff #5 began her checks around 9:30pm and caught Client #1 with no pants on. -Now staff sit in the hallways until 3rd shift staff come in to take their place in the chairs. -They had 3 staff on 2nd shift-kids can't get away with anything. -Bedtime was determined by status- Out of Order went to bed at 8:30pm; Restoring Order went to bed at 8:45pm and In Order bedtime was 9pm. -For the past month, Client #1 had been bucking up to staff-cussing and yelling back. He had	V 293		

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V 293	Continued From page 43 begun adding to his disclosure and behaviors were expected. -Client #7 would get angry too fast-can't control his anger. She was at the other hallway last night when she heard Client #7 start yelling and then heard glass breaking. Staff called the police and had all the clients come to the common area so they could be monitored. He talked to his mom following the incident but still blamed others for his behavior. Interview on 7/9/19 with Staff #3 revealed: -She had worked there for 4 years on 2nd shift but recently had a baby and returned in June. -She did not work the night of the incident (6/16/19). -Staff now required to sit in hallway. 2 hallways, 3 staff. One staff sat at dining room table and did 5-minute checks. Easier for evening staff with 3 staff than overnight with just 2 staff. -Sunday night (7/8/19) after all clients were in their bedrooms, Client #7 got angry because peers accused him of turning off water in the bathroom. He was antagonizing the other guys too. She asked him why he was so angry. Other clients kept talking back at him. He came out of his room and grabbed the clock off the table in the hall and backhandedly threw the clock toward her narrowly missing her head. He went into the milieu, grabbed a chair and threw it into the stove breaking the glass door then ran outside. Client #7 deescalated after the cops arrived. -While Client #7 was outside, Client #3 went into Client #7's room and threw his pillow and comforter out the window. -She and Staff #1 got written up 2 weeks after the incident on 6/16/19 for not supervising. -She called the Lead QP last night to say "write me up again if you have to" for Client #3 going into Client #7's room.	V 293		

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V 293	Continued From page 44 -Staff sat in hallways prior to 6/16/19 incident. "We were allowed to get up after the kids were asleep. We had to do 7-15 minute checks-now we do 5-minute checks." Interview on 7/16/19 with the LP revealed: -The LP had not attended a staff meeting in person or on the phone for two months to discuss clinical information. -The LP gave Client-specific clinical information to the Lead QP weekly, but she is not sure how the Lead QP documented this. -It was the LP's understanding that the Lead QP shared the clinical information/treatment recommendations with staff via email, the communication log or verbally. -The LP talked to the Lead QP by phone weekly, but the Lead QP was supervised by the Program Director (Registered Nurse). -The LP was not aware she needed to be providing supervision to the QP or documenting this supervision. -The LP reported she made recommendations for Client #1 during May-June 2019 as follows: --Recommendation #1: look at Medications as a possible factor in continuous erections, get a physical and do bloodwork -- Recommendation #2: Staff should encourage Client #1 to utilize the following specific coping skills: open up to staff when he is struggling, use his Mindfulness Skills (happy thoughts and review worksheet with specific skills he has), allow him to talk about his dreams in the AM (process and connect with staff so he has a positive start to the day), practice coping skills, leave the bedroom to go to the bathroom at night, redirect him to his fantasy log, and staff should be redirecting him to use his coping skills worksheet in treatment log that has exercises. -The LP reported that when she did a coping	V 293		

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V 293	Continued From page 45 skills group in the evening at the facility, the LP provided staff with skill sheets so they could help support the clients in learning/practicing skills from the group thought the week. -The LP was consulted on Client #1 being placed in a shared room with Client #2. The LP thought it was a good decision and didn't see any issues as Client #1 seemed to be managing his safety and was talking openly about it. Client #1was doing "exceptional" in therapy. -The LP reported staff were to be doing constant checking of rooms. "They do frequent checks every 5 minutes, then they do 5-10 minutes between checks, but they mix it up all night so that the clients cannot time the checks to know when to expect one." -After the incident in November 2018, the LP reported staff were to institute frequent, sporadic bed checks with an example being "one-minute staff walks the hall, then another staff walks the same hall a minute later." Interview on 7/16/19 with the Residential Coordinator revealed: -Was formerly Lead QP at this facility until 2/28/19. - Residential Coordinator reported there was an Admissions committee that determined if a client is appropriate for the offense specific program. Once a client was accepted for the program, the Program Director determined which of the two facilities the client would go to and the House Managers/Lead QPs at the two facilities determined which room the client should go to given each client's individual needs. -It was a "rule of thumb" to give new clients their own room if possible. There may be emergency/court ordered out of home placements that warrants taking a new client when a single room cannot be accommodated.	V 293		

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V 293	Continued From page 46 -Example of the type of client that might get a single room: extremely sexualized, has shown high risk behaviors, client can't distinguish between truth and a lie and can't be trusted. - Residential Coordinator was not aware if the Lead QP discussed the decision to place Client #2 with a roommate with the LP. - Residential Coordinator noted that the LP reported important clinical information to the Lead QP, such as who was in the disclosure phase of treatment and the Lead QP then passed that information along to staff, so that those clients can get additional support/safety measures. - Residential Coordinator reported some examples of additional safety measures are Peer Restriction (no contact with another specific peer), the overnight staff might supervise 2 instead of 3 clients to allow for more oversight of highly sexualized clients, staff might change seating arrangements to give a specific client less proximity to others (Example: not seat client between two clients on the couch but in an individual chair). Interview on 7/16/19 with the Program Director revealed: -The Program Director completed the intake for new clients. She asked the Lead QP what room to place the new client in. -The Program Director told the Lead QP to place Client #2 in a single room and the Lead QP stated this was not possible as she already had two clients in single rooms. -When the Program Director brought Client #2's belongings over to the facility, she was informed of the Lead QP's decision to place Client #2 with Client #1 in a shared room. The Program Director told the QP "This isn't going to work." - The Program Director told the Lead QP to talk to the LP and redo room assignments. The	V 293		

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V 293	Continued From page 47 Program Director meant to follow back up with the Lead QP to check on room assignments but did not do so. The Program Director is unsure if the Lead QP spoke with the LP regarding room assignments after she told the Lead QP to redo them. - The Program Director noted the Lead QP could have recommended holding off on the admission but noted that perhaps the QP did not feel she could make this recommendation as she was still new to her House Manager role. -The Program Director noted there was no team discussion to increase staff on the overnight shift to accommodate the increasing supervision needs of the facility. She reported they keep staff at the ratio they are required to. Review on 7/16/19 of Plan of Protection signed by the Residential Coordinator and the Program Director on 7/16/19 revealed: What will you immediately do to correct the above rule violations in order to protect Clients from further risk or additional harm? -"We have started weekly staff meetings versus monthly staff meetings. -Partitions have been put in all shared rooms -Motion Censored lights have been put in all shared rooms -Staff are required to sit in hallways all night at the present time, when staff take breaks their shift partners will walk and monitor both hallways -Discussed shift changes and implementation of monitoring clients during shift change -Disciplinary action for staff present during the last incident -Starting immediately Residential Coordinator and designees will review cameras in real time and keep a log of what was seen randomly throughout the month. The coordinator or designees will look at random dates and times to ensure all staff are	V 293		

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V 293	Continued From page 48 performing their job appropriately during high risk times (bedtime/settle time, shift change AM & PM, when the clients wake up in the AM) -Update Overnight Log -Ensure the Pass-A-Long is being completed appropriately to document all client behaviors and updates" Describe your plans to make sure the above happens. "27G 1701: Staff will sit in halls until the hours of 2am - 3am at which time they will began monitoring the halls at irregular times so clients do not become accustomed to staff routine -From hours of 3am - 6am (when clients awaken) staff will monitor halls at irregular intervals (7 to 15 minutes) -A nightly log will be completed throughout the entire night, for Both Hallway A and Hallway B, require staff initials 27G 1705: Licensed Professional will attend monthly group supervision/ staff meeting in person or via phone. This shall be reflected in program minutes, Licensed Professional attendance and safety planning and/or needed changes in pertaining to safety throughout the facility. -Update the Licensed Professional Job Description, have a meeting with the Lead QP and Licensed Professional to clarify the roles of both the QP and Licensed Professional for clinical supervision. -Licensed Professional will provide weekly supervision of the Qualified Professional and document the supervision and recommendations via email, LP log or clinical supervision form. 27G 0203: Additional Training will be provided to [Lead QP], QP by [Residential Coordinator] RC. Training will be around the following: -High Priority: Train QP on changing and updating the client PCP when consistent high	V 293		

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V 293	Continued From page 49 risk/sexualized behaviors are occurring -Specific population/Sex offender population -High risk clients sharing room and grooming behaviors -Clinically supervision of staff -Importance of reflecting accurate discussion in group supervision/staff meeting minutes around client behaviors and documenting attendance -Accurate Safety planning and when to change or update -Biweekly training /meeting will be provided to the QP from the RC 27G 0205: Licensed Professional will be responsible for CCA addendums as significant changes occur in A & C client behaviors and or high risk behaviors -At minimum Licensed Professional shall addend all CCA's every 6 months -Likewise, when addendums are completed changes may need to be made in the PCP and CCP -Licensed Professional will be required to give written weekly updates to the Qualified Professional, Residential Coordinator, Program Director, and Clinical Director via email 27G 0201: Changes shall be made in the Governing Body Policy providing criteria for room assignments for Residential Level III. The following must be taken into considerations: -High Risk Sexual Behaviors -History of past sexual behaviors -Which clients are safe to share rooms based on history -Which clients must have single occupancy room -Keep history of Room Assignments when room changes are made." The 1700 facility is licensed for 8 beds and serves adolescent boys with a history of sexually	V 293		

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V 293	Continued From page 50 aggressive behaviors. The 5- bedroom home has only 2 single rooms while the other 3 bedrooms are shared. Client #1 had previously engaged in sexual activity with a new resident in November 2018 while they shared a bedroom. Client #1 did not have a roommate again until the admission of Client #2 on 6/14/19. Despite typical programmatic procedures that allowed new residents up to 30 days in a room by themselves, Client #2 was placed into a shared bedroom with Client #1 as determined by the Lead QP. Staff #4 and Staff #5 did not have any specific information regarding Client #2 nor updated information for Client #1. No other safety precautions were put into place to protect Client #2 or monitor Client #1. On 6/16/19, two days after admission, Client #1 and Client #2 engaged in sexual activity between staff monitoring checks at around 9:45pm. The staff log of overnight checks on 6/16/19 indicated Client #1 and Client #2 were asleep from 9:25pm check until 9:55pm check. On the previous day Client #3 and Client #5 who also shared a double room, engaged in sexual activity between staff monitoring checks. (Their information was self-disclosed.) 24 cameras are mounted in the facility but no one was responsible for monitoring on a regular basis as a preventative measure. Since the 6/16/19 incident, staff reported increased supervision (tighter monitoring schedules) once clients were in their rooms. However, upon review of video from 7/15/19 at 11pm, Staff #4 was downstairs out of client area, while the Staff #5 on main floor remained reclined in hallway chair with her feet propped up and cover pulled up to her neck. No staff was walking the floor to monitor all 5 bedrooms while one staff was off the floor. The Licensed Practitioner was involved with admissions, individual/group therapy, treatment	V 293		

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V 293	Continued From page 51 planning but did not provide the Lead QP with supervision as required by rule. These failures constitute a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $1500.00 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 297	27G .1705 Residential Tx. Child/Adol - Req. for L P 10A NCAC 27G .1705 REQUIREMENTS OF LICENSED PROFESSIONALS (a) Face to face clinical consultation shall be provided in each facility at least four hours a week by a licensed professional. For purposes of this Rule, licensed professional means an individual who holds a license or provisional license issued by the governing board regulating a human service profession in the State of North Carolina. For substance-related disorders this shall include a licensed Clinical Addiction Specialist or a certified Clinical Supervisor. (b) The consultation specified in Paragraph (a) of this Rule shall include: (1) clinical supervision of the qualified professional specified in Rule .1702 of this Section; (2) individual, group or family therapy services; or (3) involvement in child or adolescent specific treatment plans or overall program issues.	V 297		

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V 297	Continued From page 52 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide face to face clinical consultation with Qualified Professional (QP) by a Licensed Professional (LP) during her 4 hours per week in the facility. The findings are: Record review on 7/16/19 for LP revealed: -Date of hire: 9/22/14 -Licensed as Licensed Clinical Social Worker. Interview on 7/16/19 with LP revealed: -The LP had not attended a staff meeting in person or on the phone for two months to discuss clinical information face to face. -The Lead QP was supervised by the Program Director (Registered Nurse). -The LP was not aware she needed to be providing supervision to the QP or documenting supervision with the QP. -The LP talked to the Lead QP by phone weekly and gave client-specific clinical information to the Lead QP, but she was not sure how the Lead QP documented this or if the information got passed on to direct care staff. Interview with the Lead QP on 7/16/19 revealed: -The Lead QP talked to the LP weekly by phone. The Lead QP did not document these calls. -The Lead QP reported the LP attended weekly staff meetings, usually by phone. Interview on 7/16/19 with the Program Manager revealed: -The Program Manager requested surveyors show her the rule where it says the QP needed to be supervised by the LP, as she was not familiar with this. - The Program Manager noted she believed the	V 297	Job Description for Licensed Professional Updated to included the information from the statue 10A NCAC 27G. 1705, specifically addressing (b) (1) (2) and (3) In addition had meeting on 7/23/2019, met with Program Director, LPs, Lead QPs, Clinical Director and Residential Coordinator, to reiterate functions of LP in providing supervision to the Lead QPs and floor staff on all client cases. In addition discussed the LP log as evidence for weekly therapy, supervision, staff meetings, and groups. Also discussed room assignments and what should take place from this time forward. LP must include phone conversations on her LP log when discussing client cases. LP now is required give weekly summaries via email to the Lead QP, Clinical Director, Program Director, and Residential Coordinator. The Lead QP is responsible for passing this information to direct care staff during weekly staff meetings and forwarding the information via email to direct care staff. An additional Clinical Learning Forum will be starting on September 17, 2019. This Learning Forum will be held on a monthly basis and will include all Residential LPs, Lead QPs, Residential Coordinator, Clinical Director and Program Director.	

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V 297	Continued From page 53 supervision of the QP was in the LP's contract as a requirement and would look into this. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 violation and must be corrected within 23 days.	V 297		