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V 000	INITIAL COMMENTS An annual and follow up survey was completed on 8-1-19. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G 1700: Residential Staff Secure for Children or Adolescents	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional.	V 110		

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This Rule is not met as evidenced by:
Based on record reviews, interviews and observation two out of three staff (Staff #1 and #2) failed to demonstrate competency. The findings are:

Review on 7-24-19 of staff #1's personnel record revealed:
-Hire date of 9-1-17
-Trainings included EBPI (Evidenced Based Protective Interventions) 1-23-19, and Common Mental Health Disorder 9-30-17.

Review on 7-24-19 of staff #2's personnel record revealed:
-Hire date of 3-28-19.
-Trainings include: EBPI 3-27-19, Special Populations Common Disorders, 3-26-19.

Review on 7-25-19 of minutes from 6-12-19 staff meeting revealed:
-"Minimum staffing requirements-Work your schedule. There must be two of you here at the facility at all times if you take a consumer somewhere all staff and consumers are to go. SIMPLE as that!"
-Both staff #1 and #2 signed meeting rooster indicating attendance.

Review on 7-25-19 of minutes from 7-17-19 staff meeting revealed:
-"Staffing ratio- MUST BE MAINTAINED AT ALL TIMES-2:1, 2:2, 2:3, 2:4 (2 staff at all times- if you go to the store, out to get lunch, to make

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V 110	Continued From page 2	V 110		

copies the entire house must go-If a staff member leaves, calls out, or is running late it is your responsibility to notify your supervisor even if they tell you they have told the supervisor.-Violations of this can lead to citations with DHSR (Division of Health Service Regulation) and can cost money.-If you are caught doing this it can lead to immediate termination."

-Both staff #1 and #2 signed meeting rooster indicating attendance.

Observation on 7-20-19 at approximately 10:30 AM-11:00 AM revealed:

-Two clients (Clients #2 and #3) and one staff (staff #1) at the facility.

-Executive Director arrives at the facility at 11:00AM.

Interview on 7-17-19 and 7-22-19 with client #1 revealed:

-There are two staff all the time.

-"Maybe one staff on the weekends."

-"Last weekend, it was [staff #1] and [staff #2], then in the morning, [staff #2] left."

-Staff #2 takes her (client #1) to her home visit and leaves staff #1 at the facility by herself.

Interview on 7-17-19 and 7-22-19 with client #3 revealed:

-There are two staff at the facility when she goes to bed and wakes up.

- On the weekends, she is woken up to receive her medication and then goes back to sleep and there are two staff at the facility then.

-"When I wake up (on weekends for the second time) she (staff #2) is gone."

-There is only one staff after that.

-She wakes up on the weekends the second time at approximately 11:00 AM.

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V 110	Continued From page 3 -It was usually staff #1 and #2 working on weekend mornings. Interview on 7-20-19 with staff #1 revealed: -Client #1 has a scheduled family visit each week on Saturday and staff #2 had gone to take client #1 to her family visit. -Staff #1 stated: "She (staff #2) takes [client #1] every Saturday and leaves us here." -She was left by herself with the remaining clients. -Staff #2 was normally away from the facility for approximately one hour when she takes client #1 to her family visit. -She couldn't recall any meeting where they talked about staffing, but she had not worked at the facility for awhile and just came back in May. Interview on 7-22-19 with staff #2 revealed: -"Let me tell you about Saturday." -"I left [staff #1] by herself, [Executive Director] said he was going there (to the facility)." -They have to have client #1 at a local Department of Social Services (DSS) branch at 10:00am for a regularly scheduled family visit. She first stated that she left the facility at 10:00 am and then stated she left approximately 9:25am. -The other two clients were sleeping when she left. "They didn't want to get up." -If the other clients are awake when it is time to leave, both staff will take all the clients. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Continued Failure to Correct Type A1 rule violation.	V 110		
V 293	27G .1701 Residential Tx. Child/Adol - Scope	V 293		

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V 293	Continued From page 4 10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (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.	V 293		

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V 293	Continued From page 5 (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care. This Rule is not met as evidenced by: Based on record reviews, interviews and observation the facility failed to ensure that services were designed to provide continuous supervision and minimize the occurrences of behaviors related to functional deficits, effecting 2 of 3 clients (Client #2 and #3). The findings are: Cross reference 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110). Based on record review, interviews and observation two out of three staff (Staff #1 and #2) failed to show competency. The findings are: Cross reference 10A NCAC 27G .1704 Minimum Staffing Requirements (V296).Based on records review, interviews and observations, the facility failed to ensure the required staff to client ratio affecting 2 of 3 clients, (#2 and #3). The findings are: Review on 7-18-19 of client #2's record revealed: -Admitted 1-26-18 -16 years old. -Diagnoses of Disruptive Mood Dysregulation	V 293		

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V 293	Continued From page 6 Disorder, Attention Deficit Disorder, and Oppositional Defiant Disorder. -Admission assessment dated 1-26-18; "discharged from a psychiatric residential treatment facility...made significant progress...needs to respect adults and use adequate coping skills...attacking mother by kicking her in the stomach requiring stitches...threatening mother and siblings." -Comprehensive Psycho Social addendum dated 1-3-18; "behaviors include sneaking, lying property destruction, unwilling to accept responsibility...past two months exponential progress...been engaged in therapy ..." -Person Centered Plan completed on 8-8-18 and last updated 6-27-19 revealed; goals include; will give positive program participation, (progress dated 6-27-19; continues to talk back to staff...does not like accepting no...will lead to verbal aggression.), will learn to use anger management techniques to avoid daily conflict, throwing temper tantrums, and anger outburst (Progress dated 6-27-19; has not developed appropriate conflict or chooses not to use it as she continues to antagonize peers...if they respond she will threaten them need staff intervention to prevent a physical altercation. Her intimidation of others had become so bad that two others had to be moved to a different facility due to her harassment.), will take responsibility for her behaviors as evidenced by not blaming others, accepting no, remaining in assigned area, being held accountable for her actions (progress dated 6-27-19, has not begin accepting to take responsibility for her actions). -Crisis Plan dated 8-8-18 included: Give her options...do not confront her, give her space and allow her to calm down....she can take a walk as long as she remains in eyesight...talk to [client #2] in a calm manner...make sure you stay at arms	V 293		

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V 293	Continued From page 7 length from [client #2] at all times. Review on 7-18-19 of client #3's record revealed: -Admitted 5-29-19. -16 years old. -Diagnoses of Post Traumatic Stress Disorder, Attention Deficit Disorder (combined type) Conduct Disorder, Unspecified Attachment Disorder, history of physical and sexual abuse (victim) Asthma, Eczema. -Admission assessment dated 5-29-19 revealed; Discharged from a PRTF (Psychiatric Residential Treatment Facility) self-injurious behavior, verbal, physical aggression, threatening peers, assaultive behaviors, pending legal charges. -Psychological Evaluation dated 2-11-19 revealed: "has also spent significant amount of time in day treatment, psychiatric facilities, residential care, juvenile detention centers...has an extensive history of disruptive and defiant behavior, conduct problems, cannabis use, aggression, self-harmful behavior (self-mutilation), agitation...has shown significant physical aggression and has been arrested for assault, running away failing drug tests and even sold drugs..." -Comprehensive Clinical Assessment summary dated 11-13-18 revealed: "hospitalized 8-30-18--9-25-18 for threatening...long history of irritability, impulsivity and aggression, depressed mood, self-injurious behavior...numerous legal charges..charges include simple assault, disorderly conduct, assault on a government official, violation of probation...enjoys being the center of attention...risky behaviors include running away, drug selling, lying, history with weapons stealing, property destruction, sexual promiscuity..." -Addendum to Comprehensive Clinical	V 293		

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V 293	Continued From page 8 Assessment dated 5-23-19 revealed; "To ensure continuity of care for [client #3] it is being recommended for her to transition to a lateral care, PRTF. However at this time, PRTF placement is not available. It is recommended for [client #3] to transition to a level 3 group home until PRTF level of care becomes available." -Person Centered Plan dated 5-29-19 revealed: 9-25-18 admitted to PRTF in which she had multiple restraints, aggression and property damage. Update 7-15-19 "Since being placed at New Place, Inc. Residential level III [client #3] ... She has constant peer conflict, refusing to comply with staff, failing to positively participate in program activities. Being in possession of contraband and requiring legal guardian visits to the facility to de-escalate her." Goals include; effectively communicate her needs and wants and gain insight/understanding of how past trauma affects mood and behavior...will develop and use age appropriate coping skills 3 out of 7 days as evidenced by; no physical aggression for 60 consecutive days, decrease verbal aggression to 1 time weekly, no anger outburst for 30 consecutive days. -Crisis Plan dated 5-29-19 revealed; let her write in her journal, give space, talk to her. Per client #3; color read, take a walk, journal. Review on 7-30-19 of Incident Response Improvement System (IRIS) revealed: -Incident on 7-24-19 with client #3 revealed: "While at the agency main office with her facility the consumer got up from where she was sitting and for no apparent reason went across the room and began punching consumer [client #1]. After staff intervened the consumer continued to use verbal aggression and eventually walked out of the office and proceeded to walk down the road. Director of Operations [DOO] attempted to follow	V 293		

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V 293	Continued From page 9	V 293		

her but the consumer continued to walk and ignore [DOO]. The police were called and charges filed for the assault and a missing person report was made."

-Incident on 7-24-19 with client #3 revealed; "The consumer was in her bedroom and Residential Counselor [staff #3] was in search of her personal keys. She asked the consumer, as she did the other consumers about her keys and the consumer became verbally aggressive. As [staff #3] told the consumer not to worry and forget the question she became upset and said that the police needed to be called because she she was about to 'tear s**t up'. When [staff #3] declined on calling the police the consumer called the police. When the police arrived the consumer had tossed things around in her room and threw other household items. While the police were talking to the staff the consumer went over to consumer [client #1] and began physically assaulting her. The police intervened and arrested the consumer for assault."

Interview on 7-31-19 with the Director of Operations revealed:

-Third shift stays over on the weekends and gets off in the afternoon when 2nd shift comes in.

-They have arranged for the home visits to be on Saturday since client #1 has a court ordered visit.

-Clients #2 and #3 often went to see their families on Saturday.

-They do everything they are supposed to do to be in compliance.

Interview on 7-31-19 with the Executive Director revealed:

-He did not see the staffing as a systems issue.

-There were always 2 staff on the schedule.

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V 293	Continued From page 10 -On 7-20-19 the Executive Director was told that all the clients were ready to go that morning. -They have had training and explained to staff the importance of two staff being in the facility at all times when clients were present. -It was not always the same staff that had been leaving the facility. "I think once it was [Qualified Professional] and once it was [the Associate Professional] -"We do immediate write ups, we address the issue." -Client #3 was not charged with assault, but with threatening on 7-24-19 Plan of Protection dated 7-31-19 and signed by the Executive Director on 7-31-19 revealed: What will you immediately do to correct the above rule violation in order to protect clients from further risk or additional harm? "meet with administration, staff, & stakeholders to address the above rule violations. A floating staff will be put in place to cover consumers scheduled appointments, to assure staffing ratio." Describe your plans to make sure the above happens. Administration will assure staffing is covered on scheduled appointments for consumers even if it means administration covers scheduled appointment to assure staffing ratio is met." On 7-20-19 one staff took one consumer to a long standing court ordered appointment, leaving one staff with the remainder of the clients (Client #2 and #3). Both staff and clients reported that this has happened on other occasions but no one could be specific as to the number of times it had happened. Both client #2 and #3 have recent	V 293		

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V 293	Continued From page 11 histories of physical aggression, threatening peers, and self harm. Client #3 has had two incidents of attacking peers (there were two staff during these incidents) were the police had to be called. Both incidents resulted in additional legal charges for client #3. Both staff #1 and staff #2 had been trained to not leave the facility with one staff. This deficiency constitutes a Failure to Correct Type A1 rule violation originally cited for serious neglect. An administrative penalty of $500.00 per day is imposed for failure to correct within 23 days. This deficiency has been cited three times consecutively: on 3-4-19, 5-2-19, 8-1-19	V 293		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as	V 296		

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V 296	Continued From page 12 follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on record reviews, interviews and observations, the facility failed to ensure the required staff to client ratio affecting 2 of 3 clients, (#2 and #3). The findings are: Observation on 7-20-19 at approximately 10:30 AM-11:00 AM revealed: -Two clients (Clients #2 and #3) and one staff (staff #1) at the facility. -11:00 AM the Executive Director came to the	V 296		

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V 296	Continued From page 13 facility. Interview on 7-17-19 and 7-22-19 with client #1 revealed: -There are two staff at all times at the facility. -"Maybe one staff on the weekends." -"Last weekend, it was [staff #1] and [staff #2], then in the morning, [staff #2] left." -Staff #2 takes her (client #1) to her home visit and leaves staff #1 at the facility by herself. -Two staff and all the clients pick her (client #1) up on Saturday evening. Interview on 7-17-19 with client #2 revealed: -"There is always two staff at the facility, never one, always two." Interview on 7-17-19 and 7-22-19 with client #3 revealed: -There are two staff at the facility when she goes to bed and wakes up. - On the weekends, she is woken up to receive her medication and then goes back to sleep and there are two staff at the facility then. -"When I wake up (on weekends for the second time) she (staff #2) is gone." -She wakes up on the weekends the second time at approximately 11:00 AM. -It was usually staff #1 and #2 working during the weekend mornings. -"Sometimes [staff #2] comes back (after dropping off client #1) and sometimes she doesn't." -There are always two staff on the second shift on the weekends. Interview on 7-20-19 with staff #1 revealed: -Client #1 has a scheduled family visit each week on Saturday and staff #2 had gone to take client #1 to her family visit.	V 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-648	A. BUILDING: _____ B. WING _____	R 08/01/2019

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

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V 296	Continued From page 14 -Staff #1 stated: "She (staff #2) takes [client #1] every Saturday and leaves us here." -She was left by herself with the remaining clients. -Staff #2 was normally away from the facility for approximately one hour when she takes client #1 to her family visit. -There had never been any incidents during the time staff #2 was gone. -She didn't know if the Qualified Professional or the Director of Operations knew one staff was being left with the remaining clients or not. -Staff #1 did not mention any other staff on the way to the facility until approximately 10:51 when she stated the Executive Director was "5 minutes away." -She couldn't recall any meeting where they talked about staffing, but she had not worked at the facility for awhile and just came back in May. Interview on 7-22-19 with staff #2 revealed: -"Let me tell you about Saturday." -They (staff #2 and client #1) met client #1's family at a local Department of Social Services (DSS) office. -"That day (7-20-19) the other car (facility vehicle) was in the mechanical shop." -"[Staff #1] was there (at the facility) when I left that morning." -"On the way back, my car broke down on me, the battery came out, that's what happened." -She then said the battery didn't actually fall out, but became so loose the car stopped running. -"We always have two staff." -"I left [staff #1] by herself, [Executive Director] said he was going there (the facility)." -"I leave around 10:00, we are supposed to be there (at the DSS office) at 10:00." -She then said she leaves the facility at	V 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 296	Continued From page 15	V 296		

approximately 9:25 am.
-The other two clients were sleeping when she left. "They didn't want to get up."
-She doesn't leave the facility with one staff every Saturday.
-"Sometimes [staff #1] takes them (all to DSS), sometimes [client #2]'s family comes for her, sometimes [client #3]'s mother comes for her." (So client's #2 and #3 aren't at the facility)

Interview on 7-22-19 with Associate Professional revealed:
-She heard about the issue on 7-20-19.
-Usually, both staff take all the clients on the Saturday visit that client #1 has to go to.
-"The other two girls don't like to get up." (that early on a Saturday).
-"I guess the other staff must have taken her (client #1) to her visit.
-"The first I knew about it was when they called me and told me you (surveyor) were here." (One staff being at the facility).

Interview on 7-22-19 with Qualified Professional revealed:
-They have discussed staffing in meetings. They have been told the facility could be fined if out of ratio.
-He had heard about staffing on 7-20-19, but had not worked that day.
-"My assumption is that people (staff #1 and #2) were allowing the girls to sleep in. The person was here (staff #1)."
- Staff #2 took client #1 to her scheduled family visit.

Interview on 7-22-19 with staff #3 revealed:
-There were two staff at the facility, even if there was only one client, there would still be two staff.

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V 296	Continued From page 16 Interview on 7-20-19 with the Executive Director revealed: -The Executive Director came in and said to surveyor: "you work seven days a week now?" -When told that surveyor had been prompted to come to the facility the Executive Director asked the clients how many staff they had told the surveyor worked on the weekend, client #2 said 2 and client #3 stated that she told the surveyor that only one staff worked on the weekend. -He had been on his way to provide coverage when he had a flat tire. -He did not have a spare so he called someone to come get the tire, take it and fix it, and put it back on his car. -He stated that he got the flat and called for assistance at approximately 10:00 AM. -He was coming because the floater (the Associate Professional) had something else to do and couldn't be there. -He stated that there are two people on the schedule at all times. -He asked if staff #1 had told surveyor he was coming. Interview on 7-20-19 with tire repair man revealed. -He answered the phone and surveyor asked him if he had done any work for the owner that morning. -The owner stated into the phone: She means the tire. -Tire repair man said yes, he had repaired the tire for the owner that morning. - He couldn't remember what time it had been. -He thought it had possibly been 7:00 AM, but really couldn't remember.	V 296		

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V 296	Continued From page 17 Review on 7-24-19 of email from County DSS revealed provided by the licensee revealed: -"To [Licensee]...It is ordered by the court that [client #1] attend every visit on Saturday's from 10:00AM-6:00PM unless she refuses to attend the visit..." Email received from Director of Operations on 7-26-19 revealed: -"I would like to include additional information on [client #1] weekend visit status to our annual survey. [Licensed professional] and I attend a permanency placement meeting today with DSS (department of social services) today and her court ordered visits have changed. Friday she will go home at 5pm and return on Sunday at 7pm. Her mother is responsible for her transportation to the group home so we are no longer responsible for any more court ordered weekend visit transportation needs. .." This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Continued Failure to Correct Type A1 rule violation. This deficiency has been cited four times since the original cite date on 8-23-18, consecutively on 3-4-19, 5-2-19, 8-1-19	V 296		