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CHANGING LIVE NOW #3	4675 HICKORY LINCOLNTON HIGHWAY NEWTON, NC 28658

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V 000	INITIAL COMMENTS A follow up and complaint survey was completed on September 4, 2019. Complaint intake NC#152231 was substantiated. Complaint intake NC# 152159 was unsubstantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and	V 108		

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V 108	Continued From page 1 implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 2 current staff (Staffs #1 and #2) and 1 of 3 former staff (FS #4) were trained to meet the mental health needs of Former Client (FC #1) as specified in his treatment plan, and failed to ensure FS #4's training in cardiopulmonary resuscitation (CPR) and first aid techniques was current. The findings are: I. Review on 8/13/19 of FC #1's record revealed: -He was 13 years old with an admission date of 5/20/19 and diagnosed Intermittent Explosive Disorder and Attention Deficit Hyperactivity Disorder (ADHD); -His 7/8/19 treatment plan had him on a behavior level system in which he earned and lost levels and privileges based on his behaviors. Review on 8/13/19 of Staff #1's personnel record revealed: -6/5/19 Relias online training on understanding ADHD for paraprofessionals. Interview on 8/15/19 with Staff #1 revealed: -FC #1 had ADHD but his problem was his anger; -He was on Level 1 because of his behavior level and he did not move to another level; -The level system was put into place by the Licensee/QP for clients to learn that when children acted out in their behaviors, there were	V 108		

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consequences of having things taken away from them;
-FC #1 was told an hour ahead of time by her to get ready to go grocery shopping and he refused after she gave him an hour to play his video game;
-She took his game away from him for a planned 3 days and he knew this was his consequence for his behavior;
-She gave his game back earlier than the entire 3 days because he was polite, took his shower and went to bed on time;
-After this incident, FC #1 was suspended 2-3 days from a local youth club for talking back at the youth club staff;
-During his suspension, FC #1 did his chores but had no privileges taken away like his video game because he wanted to stay inside and play his games instead of going out to socialize.

Interview on 8/16/19 with Staff #2 revealed:
-He did not know FC #1's mental health diagnosis;
-FC #1 had anger issues;
-If he and Staff #1 needed to go to the store, they explained to FC #1 that he could not be left alone and he was told what needed to happen and if he was angry, he had to talk about his anger;
-He learned to work with FC #1 by observations of him when he talked and how he "carried himself" when they took him out in the community to the mall;
-During his suspension from the club, FC #1 had to do his chores but was allowed outside to shoot basketball;
-FC #1 was not allowed to sit around inside the facility and play his video games on TV.

Interview on 8/15/19 with FS #4 revealed:
-FC #1 was on a behavior level system;

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V 108	Continued From page 3 -New clients started out at level 1 in which they were not allowed to do any extra activities such as additional TV time or video games, but they were allowed outside to play basketball; -A client at level 2 could go to the grocery store and on other community activities; -At Levels 3-4, a client was able to go on therapeutic leaves; -She believed the Licensee/QP put the level system in place for FC #1 to improve his behaviors because he was defiant and "mouthy;" -He was dropped a level because he cursed Staffs #1 and #2 when he refused to go shopping with them but earned his Level 2 back when he apologized to Staff #1. Interview on 8/14/19 with the Licensee/QP revealed: -All facility clients started out at level 2 because his thought was staff were not to judge the clients by their past behaviors and each client could earn their way (privileges) forward; -Each client's behavior dictated how long a client remained at a certain level; -Level 2 had additional privileges such as going to the local gym, playing basketball, and extra time playing video games during the week and on weekends; -Level 1 meant suspension from these activities and included use of the computer to watch TV programs; -It usually took 6 months to reach Level 4 for a client to be privileged to have a cell phone; -Staff understood how to implement the behavior level system with FC #1; -FC #1 dropped from a level 2 to a level 1 when he refused to go to the store and used profanity with Staffs #1 and #2; -FC #1 remained at level 1 after he snuck a cell phone into the facility when he returned from two	V 108		

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therapeutic leaves;
-4 days prior to FC #1's discharge, he observed FC #1's cell phone beside him in bed but he did not remove his cell phone because of FC #1's explosive outbursts and not knowing what the outcome was going to be regarding the 8/12/19 "state meeting."

II.Review on 8/13/19 of FS #4's personnel record revealed:
- A 6/13/19 printed certificate of completion of Relias online CPR Refresher training;
-A 6/13/19 printed certificate of completion of Relias online First Aid training.

Interview on 8/15/19 with FS #4 revealed:
-She worked as staff for the Licensee /Qualified Professional (QP) in 2016, separated her employment, and returned to work as staff on 6/13/19;
-In 6/2019, she had a refresher CPR and First Aid online training through Relias' curriculum;
-The training provided written information and videos about procedures to take if someone was unresponsive such as calling 9-1-1;
-There was a multiple-choice test at the end of the online training which was electronically scored;
-There was no hands-on practice component with the online training;
-She had an American Heart Association (AHA) card for CPR and First Aid which she gave to the Licensee /QP when she returned to work for him on 6/13/19.

Interview on 8/13/19 with the Licensee /QP revealed:
-He provided a photocopy of FS #4's AHA card, which had an issue date of 1/1/18 and a recommended renewal date of 1/31/19;

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V 108	Continued From page 5 -He had not checked to see if the AHA certification was effective; -He wanted to make sure his staff had the required training in place; -He thought the refresher CPR and First Aid courses could be completed online; -He was not aware the online courses had to contain hands-on practice. This deficiency constitutes a re-cited deficiency and is cross-referenced into 10A NCAC 27G .1301 Scope for a Continued Failure to Correct Type A rule violation.	V 108		
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	V 109		

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V 109	Continued From page 6 met the requirements of the competency-based employment system in the State Plan for 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 review and interview, the Licensee/Qualified Professional (the Licensee/QP #1) failed to demonstrate competence in his decision-making to ensure 2 of 2 current staff (Staffs #1 and #2) and 1 of 2 former staff (FS #4) met criteria for their required training. The findings are: Review on 8/13/19 of Staff #1's personnel record revealed: -6/2/19, printed certificate of completed online Relias medication training; -6/5/19 printed certificate of completed online Relias training titled "Understanding Attention-Deficit Hyperactivity Disorder (ADHD);" -6/9/19, printed certificate of completed online Relias training titled "Standard Precautions and Bloodborne Pathogens." Review on 8/13/19 of Staff #2's personnel record revealed: -6/2/19, printed certificate of completed online Relias medication management training.	V 109		

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V 109	Continued From page 7 Review on 8/13/19 of Former Staff #4's personnel record revealed: -6/13/19, printed certificates of completed online Relias training for: -Refresher Cardiopulmonary resuscitation; -Refresher First Aid; -Medication Management for Children's Services Paraprofessionals; -Bloodborne Pathogens. Interview on 8/15/19 with Staff #1 revealed: -She had online Relias training for Bloodborne Pathogens, client medication, and ADHD; -Former Client (FC #1) had ADHD but his problem was his anger; -She and Staff #2 did not work with FC #2. Interview on 8/16/19 with Staff #2 revealed: -He took a medication management course through a Relias online training; -He took an online Relias course on Positive Behavior Support, which was how to interact with children; -He did not provide examples of positive behavior supports ; -He stated he took an online test for all the Relias training; -Each online test had a passing score of 80% of correct answers; -He did not know FC #1's mental health diagnosis; -FC #1 had anger issues; -He learned to work with FC #1 by observations of him when he talked and how he "carried himself" when they took him out in the community to the mall. Interview on 8/15/19 with Former Staff (FS #4) revealed:	V 109		

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V 109	Continued From page 8 -All of her trainings for her position as direct staff were completed online with Relias and included Cardiopulmonary resuscitation and first aid, medication and bloodborne pathogens; -Each of her online training courses was followed by a multiple-choice written test, which was electronically scored; -There was no "hands-on" practice with the online training. Interview on 9/4/19 with the Licensee/QP revealed: -He had talked with a staff from another Level 2 provider who used the online Relias training; -He looked at the online curriculum and decided to go with the training because he thought they met training criteria; -He could discuss the requirements with Relias. This deficiency constitutes a re-cited deficiency and is cross-referenced into 10A NCAC 27G .1301 Scope for a Continued Failure to Correct Type A rule violation.	V 109		
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;	V 112		

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V 112	Continued From page 9 (2) strategies; (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 interview, the facility failed to develop and implement goals and strategies for 1 of 2 former clients (FC #1). The findings are: Review on 8/13/19 of Former Client (FC#1)'s record revealed: -Date of admission: 5/20/19 -Date of discharge: 8/12/19 -Diagnoses: Intermittent Explosive Disorder, Attention Deficit Hyperactivity Disorder (ADHD), Combined Presentation-Mild -Age: 13 -History: Verbal and physical aggression (refusal to comply with parental and school rules and directives, argumentative, use of profanity, bullying peers, physical acts of anger and aggression toward family members and peers), a legal charge with juvenile justice involvement, school suspensions, property destruction, and incidents of elopement from his family home;	V 112		

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V 112	Continued From page 10 -5/17/19 juvenile disposition orders included probation to 5/2020 and a Level II placement at the facility. Review on 8/13/19 of a 4/11/19 written treatment plan for FC #1 revealed: -While his short-term goals were to participate in a residential placement, which identified the facility, and comply with mental health treatment for behavior modification, FC #1 was not a resident of the facility on 4/11/19; -He had 11 objectives identified to help him meet these short-term goals and they included: -complying with attendance, rules, and treatment recommendations at the residential facility; -developing appropriate social skills to utilize within the school and social environment while increasing school attendance and/or attendance in court-ordered programs; -following the first directions and adhering to limitations and boundaries established by authority figures; -Each section in his Crisis Prevention and Intervention Plan section was stated with "See CCP;" -Staff were responsible for helping FC #1 achieve the stated goals and objectives of his plan; -The written strategies in the plan appeared to be those of a clinician and not staff; -There were no staff signatures on the plan; -The 4/11/19 plan was signed by FC #1, his legal guardian, a licensed clinical social worker (LCSW), and a physician (M.D.); -There was an addendum to the plan dated 4/30/19 and completed by the LCSW with FC #1 accepted into the Level II placement and the facility having committed to providing residential services to FC #1.	V 112		

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V 112	Continued From page 11 Review on 8/14/19 of an updated 7/8/19 written treatment plan for FC #1 revealed: -This plan was previously dated 4/11/19; -An addition to his # 4 goal objective was his attendance at a local youth club; -This plan was signed by the legal guardian and the Licensee/Qualified Professional (QP) on 7/8/19; -The action plan page included a written narrative that a Child and Family Team (CFT) meeting was held on 7/8/19 with FC #1's legal guardian, Juvenile Justice Office (DJJ), and the Licensee /QP present; -The narrative included the following information about FC #1: -He had escalated behavior after he refused to comply with staff request and follow the rules of the group home; -His demeanor during 2 crisis situations was discussed by the Licensee/QP; -He was on a behavior level system in which he earned and lost levels and privileges that were based on his behaviors; -His participation in a local youth club would be added to the treatment plan because the youth club assisted him with social skills development and leadership skills; -With exception of adding his attendance at the youth club, this narrative information about FC #1 was not developed into client-specific goals and strategies that addressed his presenting problems and needs. Review on 8/14/19 of FC #1's local youth club record revealed: -6/11/19, a written and signed application for the youth club; -Section 3 of the application, which was titled Medical History, Special Medical Needs or Concerns, had examples of medications,	V 112		

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allergies, medical conditions, and dietary needs, but had no information about FC #1's behaviors and related needs;
-There was no written information on his youth club application that indicated he had mental health diagnoses, verbal or physical aggressive behaviors, or risk of elopement;
-2 written incident reports for FC #1 completed by the local youth club staff revealed:
-The 1st report was dated 7/17/19 at 4:35 pm and had him running into another club member who pushed FC #1 back;
-He hit the other club member and a club staff member stepped in between FC #1 and the other club member;
-The 2nd report was dated 7/19/19 had a club staff instructing club members to clean up for snack time;
-FC #1 responded to the club staff's instruction to "get out of his face or else;"
-He then walked out of the club and stated to club staff he was leaving;
-He was suspended from the youth club from 7/22/19 through 7/23/19;
-The report stated that if FC #1's behavior continued, he would not be able to return to the program.

Review on 8/13/19 of FC #1's written Child/Adolescent Discharge/Transition Plan revealed:
-A printed date of 8/12/19 was at the top of the form indicated there was a Child and Family Team meeting on 8/12/19 to develop the discharge/transition plan;
-This form was signed by FC #1, his legal guardian, and the Licensee /QP on 8/12/19;
-His expected discharge date was 8/12/19;
-At the time of discharge, his anticipated transition was identified as Level II residential

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V 112	Continued From page 13 provider; -FC #1's actual discharge was home to his legal guardian and not to a Level II facility; -The Licensee /QP's written explanation for FC #1's discharge was so that his mental health needs "will continue to be met for not less than 3 to 6 months;" -He had the legal guardian responsible for FC #1's lateral Level II transition; -There was no documentation on the plan that indicated the DJJ counselor, Local Management Entity Care Coordinator, or clinical therapist were involved on 8/12/19 in FC #'1's discharge. Attempted interview on 8/15/19 with FC #1 revealed: -An interview was scheduled with him through his legal guardian for 8/15/19 at 6:00 pm; -He refused to be interviewed. Interview on 8/14/19 with FC #1's legal guardian revealed: -FC #1 was admitted to the facility in early 5/2019 but she did not recall the exact date; -From a 7/8/19 team meeting, she knew there was a possibility FC #1 might be moved to another placement because the Licensee/QP had an 8/12/19 "state meeting" and he was uncertain about the outcome of the meeting; -She received a text by the Licensee/QP the afternoon of 8/12/19 to call him ASAP (as soon as possible); -When she called him on 8/12/19, the Licensee/QP said the "state meeting" did not go well and he had to discharge FC #1 that day; -The Licensee/QP told her he wished FC #1 could have stayed at the facility and he tried to talk "the state" into letting FC #1 stay; -She picked FC #1 up at the facility between 5:00-6:00 pm on 8/12/19, signed a discharge	V 112		

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V 112	Continued From page 14 paper, and took him home with her; -FC #1 was not ready to return home because he continued with defiant behaviors; -She did not know how the facility worked with him to address his behaviors because there was one treatment team meeting held from the time of his admission in 5/2019, which was on 7/8/19; -FC #1 attended the local youth club at the time of his 7/8/19 team meeting; -She did not know if he had learned anything from being at the facility and thought staff were "lenient" with him by having allowed him to play his gaming system to keep him occupied; -She had not had a behavior level system explained to her at the 7/8/19 team meeting or by the Licensee/QP and she did not know how the system worked; -She was told at the 7/8/19 meeting that FC #1 had an anger outburst when he refused to cooperate with a staff request and he had a second incident where he got into a fight with a peer at the facility, which resulted in his television and gaming system privileges removed until he apologized to staff and a peer; -She spoke with FC #1's Care Coordinator a couple of months ago about whether she wanted to keep FC #1 in placement at the facility as she was informed there were issues around staff training and documentation; -She decided it was okay to let him continue in the placement; -FC #1 was staying at home while she and the Care Coordinator worked together to get him placed into another Level II placement; -He no longer attended the local youth club because she could not afford the cost. Interview on 8/15/19 with FC #1's legal guardian revealed: -FC #1 had uncooperative behaviors most of the	V 112		

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V 112	Continued From page 15 day and refused to follow her requests; -The Care Coordinator informed her on 8/15/19 that FC #1 was approved for the other Level II placement which she anticipated to occur the following week. Interview on 8/14/19 with FC #1's Local Management Entity (LME) Care Coordinator revealed: -His facility admission date was 5/18/19; -His initial treatment plan was completed on 4/11/19 by a licensed clinical social worker (LCSW) as a result of a referral from juvenile justice for outpatient therapy after intensive in-home services were unsuccessful; -She believed the Level II residential service was added to his plan on 4/30/19 as part of a juvenile justice recommendation; -She talked with the Licensee/QP the week of 8/7/19 and understood FC #1 might have to transitioned from the facility to another Level II placement after a "state meeting" on 8/12/19; -She called the Licensee/QP on 8/13/19 and was "surprised" to hear FC #1 had been discharged home the evening of 8/12/19 to his legal guardian; -Her surprise about FC#1's discharge was because FC #1's placement at the other Level II facility had not been secured; -The Licensee/QP was responsible to assist the legal guardian to transition to the other provider; -The reason given to her by the Licensee/QP about FC #1's discharge was the "state meeting did not go well;" -Her call to the legal guardian on 8/13/19 indicated FC #1 had made some progress in his placement but he had a continued need for placement. Attempted interviews on 8/14/19 and 8/15/19 with	V 112		

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V 112	Continued From page 16 FC #1's DJJ's office revealed: -A voice mail message left on both dates with a request for a return telephone call; -No response from the officer as of 9/4/19. Interview on 8/14/19 with a unit director of the local youth club revealed: -6/17/19 was FC #1's first day of attendance at the local youth club; -8/9/19 was his last day of attendance at the club; -He was aware FC #1 was living at the Licensee/QP's facility, had some level of anger and needed medication which was not administered to FC #1 at the club; -There was no information on FC #1's application and no written notes in his club record about physical or mental health diagnoses or behaviors related to his anger or a tendency to walk away that club staff needed to watch for; -FC #1's juvenile probation officer showed up one day and he and club staff were not made aware FC #1 was on probation or that a juvenile officer might visit him there; -He had 2 behavior incidents and was suspended for 2 days (7/22/19 and 7/23/19) as a result of the 2nd incident in which FC #1 exited the building and walked into the parking lot toward the street; -The youth club had a history of disciplinary problems with the Licensee/QP's clients in the past who did not stay long at the youth program. Interview on 8/13/19 with the Licensee/QP revealed: -FC #1 was discharged on 8/12/19 after a "state meeting;" -He was picked up at the facility around 5:00-6:00 pm by his legal guardian; -He did "a lot of thinking" after the "state meeting" and decided to discharge FC #1; -He texted FC #1's legal guardian to call him	V 112		

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V 112	Continued From page 17 during his return from the "state meeting;" -He notified her when she called that the "state meeting" did not go well, and she needed to come pick FC #1 up because he wanted to make sure FC #1's needs were met; -FC #1's Care Coordinator called him the morning of 8/13/19 to ask about the outcome of the "state meeting" and he informed her about FC #1's discharge on the previous day; -He stated a lateral transition for FC #1 to a Level II placement continued as a possibility; -FC #1's DJJ officer knew there was a possibility of his discharge from the 7/8/19 team meeting and the officer understood he had to do what he needed to do; -He did not indicate whether he had followed up with the officer about having discharged FC #1 on 8/12/19; - "I did not suddenly discharge him (FC #1); they all (FC #1's treatment team) knew I had been contemplating this discharge." Interview on 8/14/19 with the Licensee/QP revealed: -He gave FC #1's admission date as 5/20/19 based on a billing authorization dated 5/22/19; -His written admission screening was completed on 5/20/19; -FC #1's treatment goals were reviewed on 5/7/19 and his plan did not change until the 7/8/19 team meeting; -He was unable to produce a written or printed crisis prevention and intervention plan for FC #1 as part of his original and/or updated treatment plan; -The Licensee/QP believed FC #1's written crisis plan was uploaded into an electronic program which he was unable to access at the time requested; -FC #1's explosive behaviors were less frequent	V 112		

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V 112	Continued From page 18 and required no changes in his crisis plan; -FC #1 was doing well in his placement and a discussion at the 7/8/19 team meeting was about his verbal episodes and not physical episodes; -FC #1 was on a behavior level system which meant he started out at a level 2 with facility and community activity privileges and he dropped to a level 1 for not listening to staff directions and use of profanity; -Level 1 meant he lost community activity privileges such as going with staff grocery shopping and gaming time at the facility; -FC #1's legal guardian knew about his behavior level system; -FC #1 needed between 3-6 more months of placement to address his mental health needs; -Prior to FC #1's discharge, he discussed with the Level II provider who had bed availability about FC #1's diagnoses and behaviors; -He gave FC #1's legal guardian the name and telephone number of the Level II provider; -FC #1's placement was between his legal guardian, the Care Coordinator and the Level II provider; -He questioned whether FC #1's legal guardian had the ability to care for FC #1 until he was placed with the other provider; - "Was I not supposed to do it that way or something?" Interview on 9/3/19 with the Licensee/QP revealed: -He acknowledged FC #1's treatment plan was not updated; -He communicated with everyone on FC #1's team that he may have to discharge him if the outcome of the "state meeting did not go well;" -He stated he felt after the "state meeting," FC #1 could be better served by someone other than him;	V 112		

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V 112	Continued From page 19 -He was aware that FC #1 needed a higher of care than what his legal guardian might could provide at the time he discharged FC #1; -The team agreed with the decision to discharge FC #1; -FC #1's legal guardian was the only one who did not want to move forward with the discharge. This deficiency constitutes a re-cited deficiency and is cross-referenced into 10A NCAC 27G .1301 Scope for a Continued Failure to Correct Type A rule violation.	V 112		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and	V 118		

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V 118	Continued From page 20 (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to keep current the MAR for 1 of 2 former clients (FC #1) and failed to ensure 2 of 3 current staff (Staffs #1 and #2) and 1 of 2 former staff (FS #4) were trained by a legally qualified and privileged person in medication administration. The findings are: Review on 8/14/19 of FC #1's June 2019-August 2019 MARs revealed: -FC #1's prescribed medications were Concerta Extended Release (ER) 36 milligrams (mg) once daily to treat Attention-Deficit Hyperactivity Disorder (ADHD) and Abilify 5 mg once daily to treat irritability; -6-14 to 6/17/19, the Concerta and Abilify had an "L" marked for each of these dates; -An L code was designated for Leave on the 7/2019 and 8/2019 MARs; -The back of the June 2019 MARs was blank with no additional documentation that indicated the reason or type of leave FC #1 was on and whether his medication was given to family for administration. Review on 8/13/19 of FC #1's written service notes in his record had him in the facility during an 8:00 AM to 8:00 PM shift on 6/17/19.	V 118		

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V 118	Continued From page 21 Review on 9/4/19 of a written Relias course description submitted by the Licensee/Qualified Professional (QP) on 9/4/19 and titled "Medication Management for Children's Services Paraprofessionals" revealed: -The course was written by a Registered Nurse with a bachelor's of science degree in nursing (BSN) and master of education (M. Ed); -A passing score of 80 % was required on a post-test for completion of continuing education credit for the course. Review on 8/13/19 of Staffs #1 and #2's personnel records revealed: -Both these staff completed medication training on 6/2/19 through an online Relias training curriculum for paraprofessional staff for 1.75 hours; -There was no documentation that indicated these two staff had been trained by a legally qualified and privileged person in medication administration; -There was no documentation that indicated their skill competency in medication administration. Review on 8/13/19 of FS #4's personnel record revealed: -She completed medication training for children's services professionals on 6/13/19 through an online Relias training curriculum for 1.75 hours; -There was no documentation that indicated she was trained by a legally qualified and privileged person in medication administration; -There was no documentation that indicated her skill competency in medication administration. Attempted interview on 8/15/19 with FC #1 revealed: -He refused to be interviewed.	V 118		

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V 118	Continued From page 22 Interview on 8/15/19 with Staff #1 revealed: -Her staff training for medication administration was completed using the Relias online curriculum; -The training was about 2 hours in length and included videos and written information with step-by-step instructions and included medication storage, knowing the purpose of each medication, the right time and right dose of each medication, and documenting the type of medication given and at what time the medication was given; -After the training, she took an online test and had to pass with a score of at least 80; -The Relias system electronically scored the test; -There was no staff who watched her or Staff #2 pass medications to Former Client (FC #1); -She did not work with FC #2. Interview on 8/16/19 with Staff #2 revealed: -He went through a medication management training website called Relias; -He looked at pictures and read information about how to interact with children when giving them medication; -He took the training because it was required but he did not administer client medications; -Staff #1 gave the medications although he got the medications out of the locked cabinet at times for Staff #1 to give to FC #1. Interview on 8/15/19 with Former Staff (FS #4) revealed: -Her medication training was refresher medication online training which presented her with written information and an online test that was scored; - "There was no hands-on training; there's no way you could do something like that."	V 118		

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V 118	Continued From page 23 Interview on 9/3/19 with the Licensee/Qualified Professional (QP) revealed: -FC #1 was on therapeutic leave from 6/14/19 through 6/17/19 the reason the MAR was marked with an L; -He felt certain FC #1 took his medications but was uncertain if he or staff gave the legal guardian his medications to take when he went on leave because FC #1's legal guardian had not transferred his medications to the local pharmacy used by the facility; -It was FC #1's legal guardian's responsibility to have the medications transferred to the local pharmacy; -FC #1 went on therapeutic leave another time but he did not recall the specific dates of the 2nd leave; -He believed the online Relias medication training was acceptable state training because the training was done by a Registered Nurse (RN); -He checked her credentials and there had been no problems with providers being trained by Relias; -He would submit a copy of the written documentation about the online training for review and proof this training was accepted by close of the business day on 9/4/19. This deficiency constitutes a re-cited deficiency and is cross-referenced into 10A NCAC 27G .1301 Scope for a Continued Failure to Correct Type A rule violation.	V 118		
V 179	27G .1301 Residential Tx - Scope 10A NCAC 27G .1301 SCOPE (a) The rules of this Section apply only to a residential treatment facility that provides	V 179		

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V 179	Continued From page 24 residential treatment, level II, program type service. (b) A residential treatment facility providing residential treatment, level III service, shall be licensed as set forth in 10A NCAC 27G .1700. (c) A residential treatment facility for children and adolescents is a free-standing residential facility which provides a structured living environment within a system of care approach for children or adolescents who have a primary diagnosis of mental illness or emotional disturbance and who may also have other disabilities. (d) Services shall be designed to address the functioning level of the child or adolescent and include training in self-control, communication skills, social skills, and recreational skills. Children or adolescents may receive services in a day treatment facility, have a job placement, or attend school. (e) Services shall be designed to support the child or adolescent in gaining the skills necessary to return to the natural, or therapeutic home setting. (f) The residential treatment facility shall coordinate with other individuals and agencies within the client's system of care. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to operate within the scope of its license. The findings are: CROSS-REFERENCE: 10A NCAC 27G .0203	V 179		

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V 179	Continued From page 25 Personnel Requirements (V108) Based on record review and interview, the facility failed to ensure 1 of 2 current staff (Staffs #1 and #2) and 1 of 3 former staff (FS #4) were trained to meet the mental health needs of Former Client (FC #1) as specified in his treatment plan, and failed to ensure FS #4's training in cardiopulmonary resuscitation (CPR) and first aid techniques was current. CROSS REFERENCE: 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) Based on record review and interview, the Licensee/Qualified Professional (the Licensee/ QP #1) failed to demonstrate competence in his decision-making to ensure 2 of 2 current staff (Staffs #1 and #2) and 1 of 2 former staff (FS #4) met criteria for their required training. CROSS REFERENCE: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112) Based on record review and interview, the facility failed to develop and implement goals and strategies for 1 of 2 former clients (FC #1). CROSS REFERENCE: 10A NCAC 27G .0209 Medication Requirements (V118) Based on record review and interview, the facility failed to keep current the MAR for 1 of 2 former clients (FC #1) and failed to ensure 2 of 3 current staff (Staffs #1 and #2) and 1 of 2 former staff (FS #4) were trained by a legally qualified and privileged person in medication administration. CROSS REFERENCE: 10A NCAC 27G .1302 Staff (V180) Based on record review and interview, the facility failed to ensure the facility was staffed with at	V 179		

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V 179	Continued From page 26 least one direct care staff. Review on 8/14/19 of Former Client (FC #2)'s record revealed: -Date of admission: 5/20/19 -Date of discharge: 5/31/19 -Diagnoses: Disruptive Mood Dysregulation Disorder, Post-Traumatic Stress Disorder (PTSD), Generalized Anxiety Disorder (GAD), Oppositional Defiant Disorder (ODD), Migraines -Age: 13 -History: Disorderly school conduct leading to juvenile justice involvement, verbal and physical aggression (punched an older resident, verbal threats to harm peers, use of profanity), property destruction, school suspensions and elopement; -There was no documentation that indicated referrals for a substance abuse assessment; -5/9/19, a written Level III discharge facility summary had him with an emergency discharge and an expected transition to a Level III facility closer to his family's jurisdiction; -There was no written 5/31/19 discharge information. Review on 8/14/19 of FC #2's Screening and Assessment form dated 5/20/19 revealed: -He had struggled in two Level II placements and had substance use challenges; -He was placed at the facility in a Level II placement by a county department of social services (DSS); -He appeared "slightly delayed, coherent but somewhat dazed;" -He stated he liked his "happy pills;" -Placement recommendations included a structured living environment, substance abuse assessment, periodic drug screens, and ongoing therapy to address behavior struggles.	V 179		

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	MHL018-096	A. BUILDING: _____ B. WING _____	R 09/04/2019

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V 179	Continued From page 27 Review on 8/14/19 of FC #2's treatment plan dated 3/13/19 revealed: -He was admitted on 2/27/19 to a Level III residential placement and his plan was reviewed on 3/13/19 with minimal progress in his treatment; -His treatment goals were specific to Level III residential and included: -Decreased aggressive behavior and angry outbursts by utilizing coping skills to assist with anger management as evidenced by staff report; -Increased positive communication interactions by utilizing empathy and conflict resolution skills. Review on 8/14/19 of a written facility incident report dated 5/25/19 at 2:50 pm revealed: -The report was a level 1 report completed by FS #2; -FC #1 was using a social media platform to communicate with his mother instead of playing his video game; -FC #1 and FC #2 got into a fight after FC #2 told FC #1 he was wrong to use the social media platform to talk with his mother; -FC #2 held FC #1 down; -FC #1 kicked FC #2; -FC #2 grabbed FC #1's shoe and "beat him in the face causing scars and bruising;" -Former Staff (FS #2) offered ice and first aid and reported the incident to the Licensee/QP on 5/25/19 at 2:54 PM. Review on 8/14/19 of a written discharge summary from a Level III facility for FC #2 with an expected date of discharge of 5/9/19 revealed: -He was transitioned to a temporary placement due to an inability to find placement within a 30-day period; -He was expected to have a lateral transition to a Level III group setting;	V 179		

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V 179	Continued From page 28 -FC #2's transition was an emergency and was discharged out of the Level III facility to a local DSS. Attempted interview on 8/14/19 with FC #2 revealed: -He was not available for an interview and his current placement could not be determined. Interview on 8/15/19 with FC #2's Local Management Entity (LME) Care Coordinator revealed: -She confirmed FC #2 was in a Level III placement prior to his admission to the Licensee/QP's Level II facility; -She was uncertain of the date of FC #2's admission to the facility as she lost communication about him for 2 weeks before she "tracked" him at the facility; -The LME had no service contract with the facility; -FC #2 was discharged on 5/31/19 to a Level III facility in another county. Interview on 8/14/19 with the Licensee/QP revealed: -FC #2 was admitted to the facility on 5/20/19 as a temporary placement from a county department of social services (DSS); -His company was paid the room and board and therapeutic rate from the DSS for FC #2's care; -He was aware FC #2 was a Level III client; -If FC #2 was not admitted to his facility, DSS staff would have had to stay with him until a Level III placement was secured and he had a facility for him to stay temporarily; -FC #2 was at the facility for about 2 weeks and moved to a Level III facility in another county; -There was one incident of physical aggression between FC #1 and FC #2 which occurred on 5/25/19;	V 179		

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V 179	Continued From page 29 -He did not complete a discharge summary on FC #2 when he left the facility. Former Client (FC #1) and Former Client (FC #2), age 13, were admitted on 5/20/19 with histories of verbal and physical aggressions (hitting others, verbal threats to harm others, use of profanity), non-compliance with school rules and regulations and parental authority, school suspensions, property destruction, elopement, and involvement with the juvenile justice system. FC #1 was prescribed 2 medications to treat his diagnoses of Intermittent Explosive Disorder and Attention Deficit Hyperactivity Disorder (ADHD). His medications were managed daily by 2 current staff (Staffs #1 and Staff #2) and 1 former staff (FS #4). These staff were not trained by a legally qualified person in medication administration. Staff did not keep FC #1's June 2019 MAR current with the documentation. As a result, a determination could not be made as to whether he received his medication on 6/17/19 at his 8:00 AM dosage time. On 5/25/19, FC #1 had physical injuries that resulted from a physical fight with FC #2 and required a first aid response. Two weeks later, on 6/13/19, FS #4 was hired but her training in cardiopulmonary resuscitation (CPR) and first aid was not renewed by the American Heart Association or by equivalent CPR and First Aid methods. Staff #1, #2 and FS #4 knew FC #1 had anger issues and had a behavior modification system (behavior level system) in place by the Licensee/Qualified Professional but each of these staff communicated a different understanding about how to apply the behavior modification with FC #1 for improved anger management. FC #1 had no updated goals or strategies in his treatment plan between the period 4/11/19 to 7/8/19 that addressed the need for the behavior	V 179		

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V 179	Continued From page 30 modification system and how it was to be implemented. There was no documentation in FC #1's 7/8/19 treatment plan or in his record from the period 7/8/19 to 8/11/19 which indicated his possible discharge on or about 8/12/19 and a possible step down to a lower level of care. FC #1 was discharged by the Licensee/QP on 8/12/19 to a lower level of care although he had a continued mental health need for a Level II placement and there was bed availability for him. The Licensee/QP operated outside the scope of his license when he accepted admission of FC #2 who was discharged from a Level III residential facility and continued to be need of this level of care. The Licensee/QP completed a screening assessment for FC #2 on the date of his admission on 5/20/19 and accepted him for admission on his rationale that FC #2 did not need a higher level of care. He did not complete a discharge summary for FC #2 when he left the facility on 5/31/19 for admission to a Level III placement in another county. FC #2's treatment plan was dated 3/13/19 and had him with behaviors that were to be addressed with Level III treatment services and a Level III facility discharge summary dated 5/9/19 which included an expectation for him to be transitioned to another Level III placement. This deficiency constitutes a Continued Failure to Correct a Type A1 rule violation originally cited for serious neglect. An administrative penalty of $500.00 per day continues to be imposed for failure to correct within 23 days.	V 179		
V 180	27G .1302 Residential Tx - Staff 10A NCAC 27G .1302 STAFF	V 180		

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V 180	Continued From page 31 (a) Each facility shall have a director who has a minimum of two years experience in child or adolescent services and who has educational preparation in administration, education, social work, nursing, psychology or a related field. (b) At all times, at least one direct care staff member shall be present with every four children or adolescents. If children or adolescents are cared for in separate buildings, the ratios shall apply to each building. (c) When two or more clients are in the facility, an emergency on-call staff shall be readily available by telephone or page and able to reach the facility within 30 minutes. (d) Psychiatric consultation shall be available as needed for each client. (e) Clinical consultation shall be provided by a qualified mental health professional to each facility at least twice a month. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the facility was staffed with at least one direct care staff. The findings are: Review on 8/13/19 of Former Client (FC #1)'s record revealed: -Unsigned staff service notes for the following dates: -6/17/19, 6/18/19, 6/19/19, 6/20/19, 6/21/19, 6/22/19, and 6/23/19 from 8:00 AM to 8:00 PM; -6/18/19, 6/19/19, 6/20/19, 6/21/19, and 6/22/19 from 8:00 PM to 8:00 AM; -6/27/19, no times were documented on the note. Attempted interview on 8/15/19 with FC #1	V 180		

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V 180	Continued From page 32 revealed: -He refused to be interviewed. Interview on 8/14/19 with FC #1's legal guardian revealed: -The Licensee/Qualified Professional (QP) told her that "the state" had a problem with FC #1 going to a local youth club because the Licensee/QP did not have the staff at the facility to supervise him. Interviews on 8/13/19 and 9/3/19 with the Licensee/QP revealed: -8/13/19, he had no written staff schedule to provide for the period from 6/2019 through 8/2019 because his staff were live-in staff; -Current staff were Staffs #1, #2 and himself; -Former Staff (FS#3) filled in as needed (PRN) but she had another job; -The handwriting on the unsigned service notes for FC #1 looked to be that of Staff #1; -9/3/19, he did not have staff left because he was not able to make the money to pay for staff. This deficiency constitutes a re-cited deficiency and is cross-referenced into 10A NCAC 27G .1301 Scope for a Continued Failure to Correct Type A rule violation.	V 180		