

PRINTED: 09/24/2019  
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-563</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/20/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>NEW BEGINNINGS HEALTH CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5309 KYLE DRIVE RALEIGH, NC 27616</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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V 000	INITIAL COMMENTS  An Annual and Complaint Survey was completed 09/20/19. One complaint was substantiated (Intake #NC00154836); the second complaint (Intake #NC00155608) was unsubstantiated. Deficiencies were cited.  This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Level III for Adolescents	V 000		
V 109	27G .0203 PRIVILEGING/TRAINING PROFESSIONALS  10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall	V 109	The Director obtained the viewpoint from a non-biased personnel, in lieu of the reports from police that <b>DID NOT</b> actually see the video and have been reported as being very agitated because they had to be called out to the group home continually, especially when a client attempts to run away! The Director obtained results from both videos and not simply one to make a concise decision based of visual and not hear say. The Director obtained the viewpoint from the witness (peers) and staff that were actually present when the crisis incident was taking place. The Director does not understand why an auditor would not take the time to petition the court to view the footage or simply ask the Licensee to obtain a copy for their review to ensure accuracy prior to substantiating an allegation, especially when proof is available!  It fails to state that the client was attempting to RUN AWAY AGAIN for the second time!  Did DHR ask about or even know about <u>the 2<sup>nd</sup> video</u> and did they obtain the opinions of the officers? It shows the client and the accused staff talking, hugging, laughing and the accused staff apologizing for accidentally pulling her hair. Even the Sergeant (Christopher Gay) stated that it appears that the client and the accused staff have a good relationship!	Completed on 8-30-19

**RECEIVED**  
By DHRS-Mental Health Licensure at 3:32 pm, Oct 03, 2019

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bonnie Ward TITLE: \_\_\_\_\_ (X6) DATE: 10/01/2019

STATE FORM 659 JURS11 If continuation sheet 1 of 15

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V 109	<p>Continued From page 1</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on record review, video review and interview, one of two Qualified Professionals (Director/Qualified Professional #1) failed to demonstrate knowledge, skills and abilities required by the population served. The findings are:</p> <p>Review on 08/26/19 of Director/Qualified Professional (QP) #1's record revealed: -The company was established in 2004 -2018 she received a masters degree in health services administration</p> <p>Review on 08/19/19 of a "Complaint Intake and Health Care Personnel Investigations Investigation Report" dated 08/11/19 completed by the Director/QP #1 revealed: - On 08/06/19 around 4:12 PM, an allegation of abuse was made by client #2 against staff #12 -Client #2 told the police that the staff (#12) pulled her by her hair, beat her up and has done this in the past." -Witness statements were by clients and a restrictive intervention assessment signed by staff. -Written statement provided by a peer from a sister facility disclosed "I recorded [Director/QP</p>	V 109	<p><b><u>V 109 27G.0203 Privileging/Training Professionals</u></b></p> <p><b><u>Measures put in place to correct the deficient area of practice</u></b></p> <p>On 10-01-19 a mandatory board meeting was scheduled to review the findings from DHSR. Different scenarios were discussed and preventative measures/interventions were reviewed and voted on for approval by the Board.</p> <ol style="list-style-type: none"> <li>1. The agencies Attorney has updated the initial consent that continues to legally allow The BruSon Group Inc. to use tape recordings as a training measure when deemed appropriate by the governing Board. The residential home openly provides written verbiage that video recording both visual and audio while on the property shall take place. Upon admission the facility also provide this knowledge to the Guardians and allow them an opportunity to decline if these privileges are not desired.</li> </ol> <p><b><u>Measures put in place to prevent the problem from occurring again</u></b></p> <p>Our agency ensured that this rule was and continues to be met securing the legal advice from an Attorney. To satisfy DHSR, the agency has ceased tape recordings and will not allow any peer to be involved in the teaching process of advocating for their client rights by assisting in the process. The agency has limited their governing policy, per DHSR and shall not allow the clients to actively participate in the independent living /self-advocacy program as to avoid receiving a standard deficiency for V 109 27G.0203 Privileging/Training Professionals.</p>	
	<p>-Client #2 told the police that the staff (#12) pulled her by her hair, beat her up and has done this in the past." -Witness statements were by clients and a restrictive intervention assessment signed by staff. -Written statement provided by a peer from a sister facility disclosed "I recorded [Director/QP</p>		<p><b><u>Who will monitor the situation to ensure it will not occur again</u></b></p> <p>Our agency's Executive Director (Mr. Bruce Ward, Sonia Ward &amp; Board Members ) or an additional designated qualified staff will monitor the implementation to ensure that the deficiency will not occur again.</p> <p><b><u>How often the monitoring will take place</u></b></p> <p>Maintaining documentation continues to be a mandatory part of our program (Mrs. Sonia Ward, Mrs. Bridget Jeffries, and Ms. Brenda Barnes ) or a designated qualified staff will carefully monitor the implementation on a monthly or /as needed basis to ensure that the deficiency will not occur again.</p>	

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STATE FORM

1009

Maintaining documentation continues to be a mandatory part of our program (Mrs. Sonia Ward, Mrs. Bridget Jeffries, and Ms. Brenda Barnes ) or a designated qualified staff will carefully monitor the implementation on a monthly or /as needed basis to ensure that the deficiency will not occur again.

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V 109	<p>Continued From page 2</p> <p>#1] conversation with [Client #2] stating that [staff #12] did not mean to pull [client #2]'s hair. And that what [client #2] had stated about [staff #12] was also wrong and it was a lie to get people to get [Client #2] out of the group home. [Client #2] has also stated that she lied countless of other times just to leave the group home to go to a hospital."</p> <p>Review on 08/19/19 of a videotape shown by the Director/QP #1 to Division of Health Service Regulation revealed:</p> <ul style="list-style-type: none"> <li>-Client #2 looked in the direction of a recording device. The Director/QP #1 was seated behind client #2. Client #2 noted to look upward and to the left during the recording.</li> <li>-Client #2 disclosed she was not truthful on numerous occasions including the allegation made against staff #12</li> <li>-Director/QP #1 asked client #2 questions inclusive of the following (1) from who did she learn to make false allegations, (2) why was she upset (3) what was the goal for making the false allegations</li> <li>-Director/QP #1 explained to client #2 her behaviors were patterns.</li> </ul> <p>During interview on 08/21/19, peer from the sister facility reported:</p> <ul style="list-style-type: none"> <li>-She videotaped client #2 using the cell phone of the Director/QP #1</li> <li>-The recording occurred in the TV room (converted garage area). She could not recall if other clients were in the room but recalled the House Manager being in and out of the area during the recording.</li> <li>-The recording took several tapings to assure the sound and quality of the video (her hands were not always steady)</li> <li>-At the end of the taping, she and the Director/QP</li> </ul>	V 109		

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V 109	<p>Continued From page 3</p> <p>#1 viewed the video</p> <p>During interview on 08/21/19, the Director/QP #1 reported:</p> <ul style="list-style-type: none"> <li>- "We let folks know that we record. I ask the girls if they okay with being recorded. Who does the recordings is not specific. Different staff have done recordings in the past... It could've been any other client or staff that did the recording. She didn't consider client #2 processing what happened on the video and a peer recording an issue, because Client #2 said the same thing during the first audio recording of a group session with 17 other people present.</li> <li>- She did not want it to be just her and client #2 present for the video recording.</li> <li>- The peer selected to video the discussion was selected at random to record.</li> <li>- The Home Manager was back and forth in the room during the recording.</li> <li>- She did not see any difference with client taking pictures of an activity during an outing and the video recording.</li> </ul>	V 109		<p style="font-size: 2em; transform: rotate(-90deg);">Completed on 8-23-19</p>
V 512	<p>27D .0304 Client Rights - Harm, Abuse, Neglect</p> <p>10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION</p> <p>(a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66.</p>	V 512		
	<p>(b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter.</p> <p>(c) Goods or services shall not be sold to or purchased from a client except through established governing body policy.</p> <p>(d) Employees shall use only that degree of force necessary to repel or secure a violent and</p>			

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V 512	<p>Continued From page 4</p> <p>aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter.</p> <p>(e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.</p> <p>This Rule is not met as evidenced by: Based on record review, video review and interview, one of five audited employees (staff #12) subjected one of four audited clients (#2) to abuse. The findings are:</p> <p>Review on 08/19/19 of staff #12's personnel record revealed: -Hired: 11/15/17 -Training in Restrictive Intervention dated 06/05/19 in Crisis Prevention Intervention -Physician's note dated 07/31/19 "absence is physician advised due to illness or injury. This certified that they have been under my medical care for this problem. Please excuse [staff #12] from work on 07/31/19 until 08/04/19. She may return to work on 08/05/19."</p>	V 512	<p>On 10-01-19 a mandatory board meeting was scheduled to review the findings from DHSR. Different scenarios were discussed and preventative measures/interventions were reviewed and voted on for approval by the Board.</p> <ol style="list-style-type: none"> <li>The Board has voted to research and purchase another security camera system again with hopes of having the ability to obtain continual video footage for the agency, DHSR, etc. to view themselves. This will assist the group home facility, legal personnel, DHSR and other entities with having the truthful and professional ability as to not rely on others opinions and make concise decisions by having the ability to ACTUALLY view the video footage themselves for best practice. The Board has voted unanimously to move forward with this suggestion as to elevate the extreme documented patterns/trends of auditors typically taking and believing higher authorities testimonies first over the residential placements staff(that work directly with the clients daily and know their diagnosis, behaviors, etc. ), clients(that have the ability to advocate for themselves...the same way that auditors rely on their testimony when it involves questions about an allegation, etc.) and peers(peers that are actual witness), etc.</li> </ol> <p>Continual footage has not been able to be obtained due to frequency interference, the residential placement has and is surrounded by excessively tall pine trees that normally affect the residential placement technical ability to receive continual strong signals; thus the internet is often down and videos can't be reviewed on most occasions.</p>
	<p>Review on 08/19/19 of client #2's record revealed: -Admitted: 02/04/19 -Diagnoses included: Bipolar, Attention Deficient Hyperactivity Disorder, Oppositional Defiant Disorder and Post Traumatic Stress Disorder</p> <p>Review on 08/19/19 of a "Complaint Intake and Health Care Personnel Investigations</p>		<ol style="list-style-type: none"> <li>The Board has voted on adding additional intervention curriculums that have been approved by the restrictive intervention curriculum to give alternative trainings to staff to utilize in emergency situations.</li> <li>The Board has voted to limit duties when an employee returns from regular duty to light duty, even though the Medical Doctor has cleared them to work. Staff also may be instructed not to perform any form of restrictive interventions until notice is given by the agency. A lead staff will be assigned for crisis situations to avoid any deficiencies and or the illusions of abusing a client's rights, harm, abuse and neglect. When this unique occurrence happens; additional staff may be called in to assist to ensure best practice.</li> <li>The Board has voted on the use of site maps feraciously suggested by &amp; through the</li> </ol>

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<p>V 512</p> <p>Continued From page 5</p> <p>Investigation Report" dated 08/11/19 completed by the Director/Qualified Professional #1 (QP#1) revealed.</p> <p>-On 08/06/19 around 4:12 PM, an allegation of abuse was made by client #2 against staff #12</p> <p>-Client #2 told the police that the staff #12 pulled her by her hair, beat her up and has done this in the past."</p> <p>-Witness statements provided by clients present on 08/06/19 described that client #2 was upset because she could not go on an outing and because police were on site for another client, client #2 tried to run away</p> <p>-A statement written and signed by client #2 on 08/06/19 read, "I tried to run out the door because I wanted to leave with the police. When I ran out the door [staff #12] grabbed my hair to try and protect me the best way she can and I tried to harm myself with a comb."</p> <p>-Statements written by other clients did not reflect the other clients actually observed staff #12 pull client #2's hair or mistreat her</p> <p>Review on 08/19/19 and 08/26/19 of a video/audio tape shown by the Director/QP#1 to Division of Health Service Regulation revealed:</p> <p>-Client #2 looked in the direction of a recording device. The Director/QP #1 was seated behind client #2. Client #2 noted to look upward and to the left during the recording.</p> <p>-Client #2 disclosed she was not truthful on numerous occasions including the allegation made against staff #12</p> <p>-Client #2 stated she tried to get out of the house so she "wouldn't be here anymore"</p> <p>-Client #2 explained she was upset because she did not go on an outing</p> <p>-Client #2 reported she falsely told police staff had punched her and choked her in the past and she had made false allegations 3 - 4 times in an</p>	<p>V 512</p> <p>5. The Board has voted on monthly refresher course trainings documented as continued education on restrictive interventions, pertaining but not limited to client rights, how to handle crisis situations, how to document when you call the police to cover both the client and the agency from misrepresentation, auditors methods of questionings and the reasons why they don't ask direct questions and how the answers given can easily be taken out of context and documented against both clients and agency, employee rights to have a witness present due to false allegations and feeling pressured to give untruthful replies, Confidentiality Policy, Assurance and Procedures, Client/Employee Privacy Acknowledgement, Discrimination and Harassment &amp; Policy, Therapeutic Interventions, Alternative Interventions. Effective Communication, EBPT. etc.</p> <p>6. The accused staff by DHSR was placed on probation and not allowed to work with any of the clients until she was deemed 100% knowledgeable of verbal and physical redirection holds and interventions; she was also provided with direct intervention education from an outside agency as not to be deemed as a of conflict of interest or lack of knowledge by the Director from DHSR's view point The staff has scored a 100% on her testing.</p> <p>7. The Director continues to consult with other provider agencies and shall attend a DHSR training to gain additional knowledge about their rule interpretation's s and meanings. The Director has also submitted several questions directly to the Lead (DHSR)Division of Health Service Regulation, Mental Health Licensure &amp; Certification Sections Assistant Chief (ME), DHSR General Counsel (GCC) and additional Qualified Team Members(RK) per DHSR auditors. to directly perform collaborative communications and specific knowledge to questions as to avoid making the same error again. These questions were a combination from agencies to again ensure best practice and to obtain a correct understanding of some of the governing rules of DHSR.</p> <p>8. A Staff meeting was held on 8-23-19 that consisted of ongoing de-escalation therapeutic interventions and tecquines and a review of client/employee rights; role play scenarios .etc</p>
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**Measures put in place to prevent the problem from occurring again**

Our agency ensured that this rule was met as evidenced by adding this responsibility to agency's Residential Director (Ms. Brenda Barnes ) to ensure that all staff are updated on Client Rights-Harm, Abuse, Neglect, new Board approved policies & procedures .

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V 512	Continued From page 6  effort to leave the facility -Client #2 reported she wrote a letter of apology to staff #12 and staff #12 apologized to her  During interviews on 08/20/19 and 08/21/19, client #2 reported: -She had been at the facility since February 2019 -She would like to return to a previous group home -Earlier in the month, the police came to the facility for another client -She (client #2) decided the police should take her away because she didn't want to be at the facility -While the police were in the living room talking to another client, client #2 ran upstairs and out the door but Qualified Professional #2 (QP #2) and another staff member followed her and the QP #2 caught her and brought her back inside -She tried to run a second time from the TV room -Staff #12 said "[client #2] stop!" and tried to grab her but got her hand caught in client #2's hair -Client #2 reported she was not pushed -Staff #12 did not mean to pull her hair, "she was trying to keep me safe"  During interviews on 08/20/19 and 08/21/19, staff #12 reported: -She had worked at the facility about two years on various shifts -She did most of the cooking	V 512	in place and meets expectations to remain in compliance.  <b><u>Who will monitor the situation to ensure it will not occur again</u></b> Our agency's Residential Director (Ms. Brenda Barnes & Sonia Ward) or an additional designated qualified staff will monitor the implementation to ensure that the deficiency will not occur again.  <b><u>How often the monitoring will take place</u></b> Maintaining documentation continues to be a mandatory part of our program (Mrs. Sonia Ward, Mrs. Bridget Jeffries, and Ms. Brenda Barnes) or a designated qualified staff will carefully monitor the implementation on a monthly basis to ensure that the deficiency will not occur again and sooner as or determined needed.		
	-On "the chaos day", the group was downstairs when the Director/ QP#1 explained to the clients why everyone couldn't go on a particular outing -One client became upset and ran upstairs, another client spilled coffee on herself and client #2 ran upstairs and out the door but two other staff members went after her and brought her back inside -Later in the day, a client became upset and was				

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V 512	<p>Continued From page 7</p> <p>physically aggressive with staff #12 and the police were called</p> <ul style="list-style-type: none"> <li>-While the police were still present, client #2 became agitated again and tried to run again from the TV room</li> <li>-She (staff #12) had back and foot problems but tried to keep client #2 from getting out of the door</li> <li>-Staff #12 tried to grab client #2's shirt but got her hair instead</li> <li>-Director/ QP#1 met with her, debriefed the incidents of the "chaos day", discussed what could have been done differently and suggested staff #12 allow a co-worker to intervene if a similar incident occurred</li> </ul> <p>During an interview on 08/19/19, local Police Officer #1 (PO#1) reported:</p> <ul style="list-style-type: none"> <li>-He responded to a call from the facility and spoke to a consumer to explain the process of hospitalization</li> <li>-While speaking with the consumer, he noticed client #2 was grabbed and turned around by a staff member</li> <li>-He found the interaction odd so he reviewed his body camera footage when he returned to the station</li> <li>-He looked at the video while he spoke with surveyors</li> </ul> <p>During continued interview on 8/19/19, PO#1's description of what he observed on the body camera footage revealed:</p> <ul style="list-style-type: none"> <li>-The video showed client #2 entered the room PO#1 was in from the left</li> <li>-PO#1 was talking with the initial consumer and a staff member; client #2 stood and looked toward PO#1</li> <li>-Staff #12 entered the room from the right, grabbed client #2 by the back of the neck or hair and shoved her toward the "movie room" back to</li> </ul>	V 512		

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NAME OF PROVIDER OR SUPPLIER  <b>NEW BEGINNINGS HEALTH CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>5309 KYLE DRIVE RALEIGH, NC 27616</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	Continued From page 8  the right and said "To the movie room, child" -Staff #12 grabbed client #2 with her left hand and pointed with her right hand, staff #12's hand was clenched -It did not appear to PO#1 that staff #12 tried to grab client #2's shoulders -Client #2 did not lose her balance but was forcefully pushed toward the kitchen, back to the right -There was a distinct "Yank" of client #2's hair, then she was shoved  During an interview on 08/28/19 PO#2 reported: -He and PO#3 had completed training for Crisis Intervention Team -He had been in group homes on numerous occasions and knew staff were trained to redirect and restrain clients -He went to the facility twice on 08/06/19 -The first call involved a client who locked themselves in a bathroom -PO#1 arrived on site first and while speaking with the first client, he saw staff #12 pull client #2's hair -PO#1's body camera footage captured the incident between client #2 and staff #12 -He (PO#2) observed the camera footage the next day after it was uploaded to the server -Staff #12 was issued a citation for simple assault for yanking client #2's hair and pushing -The hair pull seemed out of anger not redirection."  During continued interview on 8/28/19, PO#2's description of what he observed on the body camera footage revealed: -Client #2 and staff #12 were standing in the living room -Staff #12 grabbed client #2 by her pony tail, pushed her across the chest and back and	V 512		

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V 512	<p>Continued From page 9</p> <p>directed her through the kitchen to the TV room</p> <ul style="list-style-type: none"> <li>-The hair pull was hard enough to "jerk" client #2's head, "like a yank"</li> <li>-Client #2 did not fall nor change direction</li> </ul> <p>During an interview on 08/23/19, PO#3 reported:</p> <ul style="list-style-type: none"> <li>-She recalled going to the facility around 08/06/19</li> <li>-Initially PO#1 responded to a call from the facility due to a client locking herself in the bathroom</li> <li>-When PO#3 arrived at the facility, she heard a disturbance through the kitchen; she walked over and observed staff #12 yelling to client #2 to sit down and client #2 said "You pulled my hair! Why did you pull my hair and choke me?"</li> <li>-Things calmed down and officers spoke with the client that had locked herself in the bathroom about communicating her needs to staff</li> <li>-The officers left but were called back because the initial client had assaulted staff #12</li> <li>-While present, client #2 told an officer staff should not put their hands on her</li> <li>-She, (PO#3), was later able to view body camera footage recorded by PO#1</li> </ul> <p>During continued interview on 08/23/19, PO#3's description of what she observed on the body camera footage revealed:</p> <ul style="list-style-type: none"> <li>-Client #2 and staff #12 were in the living room where an officer was speaking to another client</li> <li>-Client #2 was standing off to the side, kind of facing the officer</li> <li>-Staff #12 who, stood beside client #2, quickly yanked client #2's hair in the direction she wanted her to go; staff #12 released the client's hair and guided her toward the kitchen</li> <li>-Staff #12 said "Downstairs, child"; client #2 did not stumble and she was not resistant</li> <li>-The yank of client #2's hair by staff #12 "was not gentle"</li> </ul>	V 512		

Division of Health Service Regulation

STATE FORM

0066

JURS11

If continuation sheet 10 of 15

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V 512	<p>Continued From page 10</p> <p>During an interview on 08/20/19, Internal Affairs Officer (IAO) reported since surveyors were not in the video footage, it was not likely surveyors would be permitted to view the footage. The IAO explained surveyors could petition the court to view the footage. The IAO did view the footage.</p> <p>During continued interview on 8/20/19 is the IAO's description of what he observed on the body camera footage revealed:                      -PO#1 was talking to a consumer wanting to leave the facility and to a staff wanting the consumer taken to a crisis facility                      -In the background, a girl (client #2) was standing in the area where PO#1 and the initial consumer were speaking                      -A woman (staff #12) came up and told client #2 to move                      -Client #2 is grabbed by her hair/neck and pushed forward by staff #12                      -Client #2 did not stumble or fall; client #2 was not resisting</p> <p>During continued interview on 08/20/19, the IAO reported he "would not expect a person in authority to treat anyone like that."</p> <p>During an interview on 08/19/19, local Police Sergeant (PS) reported surveyors would have to submit paperwork to the Internal Affairs division in order to see the body camera video taken by PO #1.</p>	V 512	
	<p>Review on 08/19/19 and 08/26/19 of a 4 minute 13 second video Director/QP #1 had made of client #2 revealed the Director/QP #1 explained:                      -Client #2's behavior was a pattern.                      -She did not think staff #12 pulled client #2's hair to cause injury or harm</p>		

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V 512	Continued From page 11  During an interview on 8/26/19, the Director/QP#1 reported measures she put in place on 8/6/19 included: reporting incidents to Health Care Personnel Registry (HCPR) and Department of Social Services (DSS), attempted to enter information into Incident Reporting Improvement System, debriefed with clients and staff to determine what could have been done differently. During the debriefing, the Director/QP#1 determined client #2 recanted her allegation that staff #12 choked her or did anything to intentionally harm her. The Director/ QP#1 determined the allegation made by client #2 was unsubstantiated.  Review on 08/29/19 of a Plan of Protection dated 08/29/19 completed by the Facility's Associate Professional revealed: -1. "What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm?" Upon finding out about the allegation by staff the agency held a staff meeting on August 23, 2019. The Staff meeting consisted of a review of the allegations and a mandated refresher course of escalation techniques to utilize when a client is attempting to run away, self harm or in general. The staff participated in different role play scenarios (and developed a code word to use when one staff may seem to be the trigger. <del>Additional training's shall be hold monthly to</del> ensure the safety of all clients and to further promote and educate all staff. The staff was placed on probation until deemed 100% knowledgeable of verbal and physical redirection, holds and restraints. If this plan is not acceptable to the state, the staff will be immediately released. -2. "Describe your plans to make sure the above happens. A mandated staff meeting was	V 512		

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NAME OF PROVIDER OR SUPPLIER  
**NEW BEGINNINGS HEALTH CARE**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**5309 KYLE DRIVE  
RALEIGH, NC 27616**

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V 512	<p>Continued From page 12</p> <p>held on 8-23-19 that consisted of the above stated trainings to provide additional and ongoing continual de-escalation updates and review of client rights."</p> <p>Client #2 was a 13 year old female with diagnoses of Bipolar, Attention Deficient Hyperactivity Disorder, Oppositional Defiant Disorder and Post Traumatic Stress Disorder. Video footage secured by local police body camera supported staff #12 yanked client #2 by the hair and pushed her toward the area with the other clients. As a result, staff #12 was charged with simple assault. These types of aggressive acts (yanking and pushing clients) constitute a Type A1 rule violation for serious abuse and must be corrected within 23 days. An administrative penalty in the amount of \$1000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of \$500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.</p>	V 512		
V 742	<p>27G .0304(a) Privacy</p> <p>10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (a) Privacy: Facilities shall be designed and constructed in a manner that will provide clients privacy while bathing, dressing or using toilet facilities.</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure privacy for one of three audited clients (#5). The findings are</p> <p>Observation and tour on 08/20/19 at 2:15 PM of</p>	V 742		

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NAME OF PROVIDER OR SUPPLIER  
  
**NEW BEGINNINGS HEALTH CARE**

STREET ADDRESS, CITY, STATE, ZIP  
**5309 KYLE DRIVE  
RALEIGH, NC 27616**

**V 742 27G.0304 Facility Design**  
**Measures put in place to correct the deficient area of practice**

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V 742

Continued From page 13

the facility revealed:  
-Posted signs outside the facility to indicate the facility was being monitored by cameras  
-Client #5's bedroom-Camera in the upper left corner

Review on 08/26/19 a letter dated 08/27/19 from a technical services company revealed:  
-"As the IT person for equipment located at 5309 Kyle Drive, Raleigh NC 27612, I can certify that the cameras have not worked since early 2016 and were due to be removed, repositioned and replaced with an upgraded unit."

During interviews between 08/20/19 and 08/30/19, client #5 reported:  
-She had not had a roommate in four months

Review on 08/19/19 of client #5's record revealed:  
-Admitted: 02/09/19  
-Diagnoses: Conduct and Depressive Disorders  
-Signed videography consent dated 02/09/19 by the legal guardian indicated permission given for the agency and/or contract agencies to photograph, video and/or audio record client. The recordings would be used for staff training, client instruction, client treatment, education and police identification. The consent will be used during participation in the following programs: ~~administration, case management, clinical~~ residential, outpatient and vocational. The consent could be revoked verbally or in writing at any time but that remained valid to the extent that recordings made under consent have already been used for training and/or supervision purposes.

During interviews between 08/19/19 and 08/27/19 with three staff and three clients revealed:

V 742

On 10-01-19 a mandatory board meeting was scheduled to review the findings from DHSR. Different scenarios were discussed and preventative measures/interventions were reviewed and voted on for approval by the Board.

- The agency did provide the auditors with a letter on company letterhead from the contractor that installed the cameras stating that the cameras haven't working for 3 years. The same cameras that have not been working for 3 years and located in the exact same place were removed to satisfy DHSR. Multiple audit interviews have been documented and completed and the Licensee has let parties know that due to poor internet service the cameras don't work. The Licensee also tells auditors that the clients don't know that they aren't working because it has proven to keep down arguments and misbehaviors. The auditors were aware that the previous room used to be a client TV room and that no initial cameras were installed when changed over to a client bedroom! It is the policy of the group home that client are not allowed to dress in their bedrooms.
- Posted signs have been at the facility since 2014. The same camera has been there for over 3 years as the previous room used to be a client TV room and that no initial cameras were installed when changed over to a client bedroom. It is the policy of the group home that client are not allowed to dress in their bedrooms. If the auditors had asked the Licensee, about the Cameras, they would have been updated as to what the license tells staff and clients. As always stated to auditors, the staffs do think that they work as it helps to promote honesty both among the clients and staff.

Completed on 8/30/19

The empty camera shell has been removed to satisfy DHSR's current request for removal.

**Measures put in place to prevent the problem from occurring again**

Our agency ensured that this rule was and continues to be met simply removing the empty camera shell to satisfy DHSR's current request for removal.

**Who will monitor the situation to ensure it will not occur again**

Our agency's Executive Director (Mr. Bruce Ward, Sonia Ward & Board Members ) or an additional designated qualified staff will monitor the implementation to ensure that the deficiency will not

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V 742	<p>Continued From page 14</p> <ul style="list-style-type: none"> <li>-All believed the cameras located in the group home worked</li> <li>-One client reported the images captured by the video cameras were erased every 7 days</li> <li>-No staff noted they had seen shown images from the video cameras located throughout the group home</li> </ul> <p>During interview on 08/20/19, DHSR construction surveyor reported:</p> <ul style="list-style-type: none"> <li>-Cameras either working or not working should not be in client bedroom areas.</li> </ul> <p>During interviews between 08/20/19 and 08/30/19, the Director/Qualified Professional #1 reported:</p> <ul style="list-style-type: none"> <li>-Due to location of the group home being surrounded by trees, the agency previously could not sustain Internet service for the cameras to fully operated</li> <li>-Within the past few weeks, the agency had discussed upgrading the camera/security system to a commercial grade with hopes to minimize the Internet accessibility concerns.</li> <li>-At this time, the cameras inside the group home were inoperable</li> <li>-No clients had mentioned concerns about the camera in the bedroom</li> </ul>	V 742	<p>occur again.</p> <p><b><u>How often the monitoring will take place</u></b> Maintaining documentation continues to be a mandatory part of our program (Mrs. Sonia Ward, Mrs. Bridget Jeffries, and Ms. Brenda Barnes ) or a designated qualified staff will carefully monitor the implementation on a monthly or /as needed basis to ensure that the deficiency will not occur again.</p>	
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**THE Bruson Group**  
A Division of The Bruson Group, Inc.

7417 Knightdale Blvd  
Knightdale, NC 27545  
(O) 919.261.8566  
(F) 919.261.8569

# Fax Coversheet

TO: Dept of Health & Human Services FROM: Bruson Group  
 FAX: 919-715-8078 PAGES: 19  
 PHONE: \_\_\_\_\_ DATE: 10-3-19  
 RE: \_\_\_\_\_ CC: \_\_\_\_\_

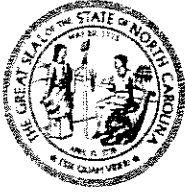
NUMBER OF SHEETS INCLUDING FAXED INCLUDING COVER:

COMMENTS:

**RECEIVED**  
 By DHRS-Mental Health Licensure at 3:32 pm, Oct 03, 2019

This fax/electronic message may contain information that is confidential and/or legally privileged; it is intended only for use of the individual(s) and entity named as consumers in the message. If you are not an intended consumer of this message, please notify the sender immediately. Do not deliver, distribute or copy this message and do not disclose its contents or take any action in reliance on the information it contains.





NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**

ROY COOPER • Governor

MANDY COHEN, MD, MPH • Secretary

MARK PAYNE • Director, Division of Health Service Regulation

September 25, 2018

Sonia Ward, Administrator  
The Bruson Group, Inc.  
4225 Coldwater Springs Drive  
Raleigh, NC 27616-8419

RE: Annual and Complaint Survey completed September 20, 2019  
New Beginnings Health Care, 5309 Kyle Drive, Raleigh, NC 27616  
MHL # 092-563  
Intake #NC00154836 and #NC00155608  
E-mail Address: allmightegod@aol.com

Dear Mrs. Ward:

Thank you for the cooperation and courtesy extended during the Annual and Complaint Survey completed September 20, 2019. One complaint was substantiated. The second complaint was unsubstantiated.

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

**Type of Deficiencies Found**

- Type A1 rule violation is cited for 10A NCAC 27D .0304 Protection from Harm, Abuse, Neglect and Exploitation (V512).
- All other tags cited are standard level deficiencies.

**Time Frames for Compliance**

- ~~Type A1 violation must be **corrected** within 23 days from the exit date of the survey, which is October 13, 2019. Pursuant to North Carolina General Statute § 122C-24.1, failure to correct the enclosed Type A1 violation by the 23<sup>rd</sup> day from the date of the survey may result in the assessment of an administrative penalty of \$500.00 (Five Hundred) against The Bruson Group, Inc. for each day the deficiency remains out of compliance.~~
- Standard level deficiencies must be **corrected** within 60 days from the exit of the survey, which is November 19, 2019.

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION 1800 Umstead Drive, Williams Building, Raleigh, NC 27603  
MAILING ADDRESS 2718 Mail Service Center, Raleigh, NC 27699-2718  
www.ncdhhs.gov/dhsr • TEL 919-855-3795 • FAX 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

September 25, 2019  
Sonia Ward  
The Bruson Group, Inc.

**What to include in the Plan of Correction**

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

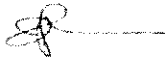
Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. **Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.**

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

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

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Renee Kowalski at 919-552-6847.

Sincerely,



India Vaughn-Rhodes  
Facility Compliance Consultant I  
Mental Health Licensure & Certification Section



Toni Rankin-Green  
Facility Compliance Consultant I  
Mental Health Licensure & Certification Section

Cc: [qmemail@cardinalinnovations.org](mailto:qmemail@cardinalinnovations.org)  
[DHRSR@Alliancebhc.org](mailto:DHRSR@Alliancebhc.org)  
Pam Pridgen, Administrative Assistant