PLAN OF CORRECTION

LH2

Annual and Complaint Survey completed on January 31, 2020

KMG Holdings, Inc.

The Lighthouse II of Clayton

2016 Fort Dr.

Clayton, NC 27520

MHL-051-138

PLAN OF CORRECTION

Annual and Complaint Survey completed January 31, 2020

V112 27G .0205 Assessment/Treatment/Habilitation Plan

10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan

During the Annual and Complaint Survey the following deficiencies were noted:

1. Facility failed to develop and implement strategies to address elopement affecting three of three current clients.

Solution:

KMG Holdings, Inc. Leadership Team has implemented a team conference call meet every weekday morning at 7:00 am to discuss strategies to address consumer elopement as well as other issues. During the call the Clinical Director/LP and Qualified Professional leads the discussion around consumer elopement from the previous day. If there were elopements from the previous day they will ascertain the circumstances that lead up to that elopement. Strategies such as utilizing any discharge instructions that may be suggested on discharge paperwork from the hospital due to an IVC that may be incorporated into treatment/PCP, contacting the discharging hospital to discuss strategies to deter elopement, reviewing the current consumer Crisis Plan to determine whether or not it needs to be updated, adding or modifying current PCP goals, having discussions with the consumer who eloped to identify the reason(s) for elopement, having discussion with the consumer who eloped to assist with identifying additional coping

mechanisms that can be implemented, discussing whether or not an emergency Medication Management appointment is necessary for a possible medication adjustment, adding window alarms within the facility, possible staffing changes that may be required to deter elopement (i.e. different and more effective staff working with the consumer, bringing in additional staff to assist during the evening shift), possibly creating a Weekend Manager position so there is management present during the weekend, possibly creating a daily rotation where a member of management talks with the consumers one on one to identify issues that are occurring that might cause elopement, identifying any training needs for the direct care staff, continuing to hire and train new staff members, etc. Once strategies are identified that are deemed appropriate they are communicated daily to staff so they are equipped with the latest information and they can be as effective as possible when working with the consumers.

V 293 27G. 1701 Residential Tx Child/Adol-Scope

10A NCAC 27E .1701 Scope

Cross reference 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan

During the Annual and Complaint Survey the following deficiencies were noted:

1. The staff failed to provide continuous supervision for 3 of 3 clients to ensure safety and minimize the occurrence of behaviors related to elopement.
2. The facility failed to develop and implement strategies to address elopement affecting 3 of 3 current clients.

Solution:

The KMG Holdings, Inc. requires its staff to provide line of sight supervision of consumers at all times. The Leadership Team has begun to have staff meetings within the group home facilities. During these staff meetings the Leadership Team provides training to the direct care staff as how to provide line of sight supervision as it pertains to all shifts. Staff are trained on not being on their cell phones, not being seated while consumers are there and are moving around the facility, overnight staff are trained to have at least one staff member sitting in the hallway throughout the night while the other performs 15 minute bed checks. Staff members are reminded that if a consumer leaves the common area then a staff member needs to follow the consumer to ensure line of sight supervision is maintained. Staff are trained to notify management immediately in the event a consumer elopes while they are providing line of sight supervision. The Leadership Team feels that if our staff members are providing the line of sight supervision and the strategies listed in V112 this may deter consumers from eloping. The team also feels that if the consumer does decide to elope immediate action can take place by the staff member notifying management and following the agency elopement policy.

V 537 27E .0108 Clients Rights – Training in Sec, Rest & ITO

10A NCAC 27E .0108 Training in Seclusion, Physical Restraint, and Isolation Time-Out

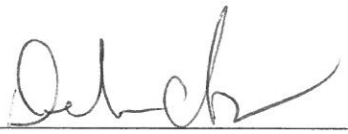
During the Annual and Complaint Survey the following deficiencies were noted:

1. The Facility failed to ensure that one of one staff demonstrated the competence to use physical restraint techniques for 1 of 3 clients.

Solution:

The KMG Holdings, Inc. utilizes Safety Care as our restrictive intervention tool. The agency Qualified Professional is the certified Safety Care instructor for the agency. The Qualified Professional has met with the affected staff member and provided refresher training in Safety Care. The refresher training consisted of Part 1 (verbal de-scalation techniques) and Part 2 (therapeutic holds). The Qualified Professional has also scheduled additional days where he is going to provide refresher training to all staff members. Safety Care will also be discussed and techniques will be demonstrated during all agency staff meeting going forward. This will be accomplished by utilizing role plays.

Respectfully submitted,



Delwin Clark, Dir. Of Operations

2/27/20

Date

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-138	A. BUILDING: _____ B. WING _____	01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIGHTHOUSE II OF CLAYTON	2016 FORT DRIVE CLAYTON, NC 27520

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and complaint survey was completed on January 31, 2020. The complaints were substantiated (Intake #NC00160071, NC00160335, and NC00160294). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. A sister facility is identified in this report. The sister facility will be identified as sister facility A. Staff and/or clients will be identified using the letter of the facility and a numerical identifier.	V 000	DHSR-Mental Health FEB 7 2020 Lic. & Cert. Section	
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (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	V 112		

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V 112	Continued From page 1 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 observation, record reviews and interviews the facility failed to develop and implement strategies to address elopement affecting three of three current clients (#3, #4, and #5). The Findings are: Review on 1/24/2020 of client #3's record revealed: - Admission date of 9/20/19. - Diagnoses of Oppositional Defiant Disorder, Unspecified Trauma and stressor - Admission Assessement dated 9/20/19 revealed a history of elopement. - Treatment Plan dated 12/9/19. Further review revealed client #3's plan did not include interventions nor strategies to address his behaviors of elopement. Review on 1/24/2020 of client #4's record revealed: - Admission date of 7/15/19. - Diagnoses of Post Traumatic Stress Syndrome, Oppositional Defiant Disorder, and Reactive Attachment Disorder - Admission Assessement dated 7/11/19 revealed a history of elopement. - Treatment Plan dated 12/09/19. Further review revealed client #4's plan did not include interventions nor strategies to address his	V 112		

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V 112	Continued From page 2 behaviors of elopement. Review on 1/24/2020 of client #5's record revealed: - Admission date of 7/20/19. - Diagnosis of Bipolar Disorder - Admission Assessement dated 7/20/19 revealed a history of elopement. - Treatment Plan dated 12/13/19. Further review revealed client #5's plan did not include interventions nor strategies to address his behaviors of elopement. Review on 1/24/2020 of former staff #1's record revealed: - Hire date of 5/9/19. Review on 1/24/2020 of staff #2's record revealed: - Hire date of 5/5/18. Review on 1/29/2020 of a local Sheriff Department 911 call report generated on 1/29/2020 revealed: - January 8, 2019 through January 27, 2020 - a total of: 40 (911 calls were made by the facility) - 14 of the 40 calls were elopement calls Review on 1/29/2020 of an incident report dated 11/11/19 with an approximate time of 12:00am revealed: "The consumer (client #5) returned to the facility at 12am from the incident of running away from the facility with his friends. The consumer repeatedly rang the doorbell and when staff opens he requested to come into the facility. Staff explained to the consumer that he needed to be searched before entering the house. Consumer refused to be searched; Laughing and yelling at	V 112		

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V 112	Continued From page 3 staff, asserting, "I don't have anything. You can't strip search me. Let me in this house. Staff then requested the consumer to be searched yet again and he refused; continuing to horseplay with his peers. Staff spoke with management on the telephone to clarify the situation at hand. Management stated that the consumer is not allowed in the house until being searched. While the staff was speaking with the 911 operator, the consumer continued disrespectful behaviors, jumping in the facility vehicle and ran across the street to sit in the grass on another property. While monitoring the consumer, he remained sitting in the grass for approximately 5 minutes. He then stood up and ran back over to the facility and looked at the staff member and stated, "stop looking at me before I put my d**k on you". Then ran back across the road yelling and laughing with his peer. When the police arrived, the consumer walked across the street, back towards the facility and waited on the officer to search him. After being searched by the officer, staff allowed the consumer to enter into the facility. Be seated on the sofa until he was allowed to go to his designated area. After handling a separate situation, the officer requested to have a discussion with the consumer retreated to his bedroom area for bedtime. Staff remained in the hallway area of the facility to monitor the consumer throughout the night." Review on 1/29/2020 of an incident report dated 12/10/19 with an approximate time of 1:30pm revealed: " consumers (client #3) eloped from the facility at	V 112		

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V 112	Continued From page 4 1:30pm. Staff attempted to unsuccessfully look for the consumer. The consumer was returned to the facility round 8:58pm by the [local police]. The consumer is facing charges for stealing several items at Walmart." Review on 1/29/2020 of an incident report dated 1/1/2020 with an approximate time of 5:00pm revealed: "[client #3] had been AWOL (Absent without Leave) from our program for several days. His AWOL actions were previously reported to local law enforcement, [sheriff department] located [client #3] while he was in the community. He was taken into custody and transported to [local hospital] and IVC'd (Involuntary Committed)." Review on 1/29/2020 of an incident report dated 1/1/2020 with an approximate time of 7:00pm revealed: "Around 7:00pm staff found a cellphone beside [client #4's] bed. Staff asked him about the cellphone and [client #4] put the phone inside his pants. [Client #4] began being defiant. [client #4] took out the cellphone and tried calling his brother. Staff stood close to [client #4] to ensure he was not making a phone call. [Client #4] tried to reach for staff so staff placed him in a floor seated stability hold. The other staff member assisted with the therapeutic hold. [Client #4] stated he was ready to talk to staff about the incident. [Client #4] gave the phone to staff and explained that he needed to talk to his girlfriend. The authorities were contacted regarding the event. They responded but did not take any action other than communicate to both staff and [client #4]." Review on 1/29/2020 of an incident report dated 1/1/2020 with an approximate time of 4:50pm	V 112		

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V 112	Continued From page 5 revealed: "Staff members were preparing dinner with consumers. [client #3] wanted to take a walk in the neighborhood. Staff told consumer [client #3] that it wasn't the appropriate time to take a walk because dinner was being prepared. Consumer [client #3] didn't like the answer he received from the staff and left the facility (unauthorized). [Local Sheriff Department] was contacted. Consumer [client #3] returned to the facility around 5:05am." Review on 1/29/2020 of an incident report dated 1/6/2020 with an approximate time of 4:50pm revealed: "Consumer (Client #3) asked staff if he could change his clothes at 12:15pm. Staff noticed consumer room door was still shut at 12:30pm and opened the door. Consumer's window was opened and consumer eloped from premises. Staff searched for consumer and could not find him. Staff called [local Sheriff Department] at 1:10pm. [Sheriff Department] arrived at the facility at 1:40pm. Consumer returned to the facility at 9:21pm. He was dropped off by someone. Consumer would not divulge who dropped him off. Staff called Sheriff Department at 9:22pm to report the consumer had returned to the facility. The Sheriff Department arrived at the facility at 10:22pm to talk to the consumer. Sheriff deputy left the facility at 10:45pm. Staff monitored the consumer throughout the night." Review on 1/29/2020 of an incident report dated 1/20/2020 with an approximate time of 8:30pm revealed: "At approximately 8:30pm staff was conducting bed checks to ensure the consumers (client #4 and #5) was in the bed and asleep. Upon entering the room staff noticed the window was opened and the consumer was gone. Staff called	V 112		

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V 112	Continued From page 6 Management to inform them of the situation and once the call was completed they called the sheriff's office to report the consumer had ran away." During an interview on 1/28/2020 client #3 stated : - He admitted running away from the facility approximately 6 to 10 times. - "I was placed in the Detention for violating my probation due to my runaway behaviors." - He admitted running away with client #4 and #5. He further stated there were times they coordinated runaway episodes with clients from the other facility (Sister Facility A). - Client #3 acknowledged there were no alarms on the facility's windows or doors. - "I'm dealing with alot with my mother and I have a history of running to cope with my problems. I'm not a bad kid." - Surveyor asked client #3 if any of the staff were assisting him with other alternative coping strategies rather than running away and his answer was no. - He did admit to attending group sessions with the LP approximately twice since his admission date. During an interview on 1/29/2020 client #4 stated: - "I've ran away from the group home over 8 times. I have ran with other guys from the other facility as well as by myself." - He acknowledged running away from the facility approximately two weeks ago and hitchhiking a ride to his father's home approximately 3 hours away from the facility. "My father brought me back to the group home the next day." - "I have been under a lot of stress." He did not go into detail of what was causing his stress. -" [Staff #2] punched me in the face recently	V 112		

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V 112	Continued From page 7 because I refused to give up my cellphone. One of the female staff called [staff #2] he was working at the other group home. He came to the house I was at and tried to take my phone. I refused to give it to him so he pushed me and grabbed me. We fell onto the floor and my forehead on the rightside was cut." - Surveyor observed a discolored scar on the left side of client #4's forehead. It was approximately the size of a 25 cent coin in diameter. - "No other staff nor other clients witnessed the incident. It occurred in the livingroom area." - Surveyor asked client #4 where was the other clients and staff at the time of the incident and he stated, in the other clients room assisting them. Note: Surveyor attempted to talk to client #5 on 1/29/2020, but he refused. During an interview on 1/28/2020 the Program Director stated: - "I've been in this position since November 2019 - "I'm responsible for overseeing the day to day operations of both facility's." - She acknowledged that elopement incidents has occurred at both facility's. She further acknowledged not having the exact number of incidents, but confirmed the frequency at both facility's were more than 5 times. - She acknowledged each time clients leave the facility they usually call 911 as a form of intervention. - "We have two staff on duty on each shift". She acknowledged not adding additional staff coverage for neither facility when elopement incidents occur. - "We have staff meetings to discuss elopement incidents both with the Direct Care Staff (Paraprofessionals) and on the Management Level (Owner, Direct of Operations, Licensed	V 112		

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V 112	Continued From page 8 Professional, Qualified Professional, and Program Director)." - "I'm responsible for developing treatment plans for all clients. [License Professional] assist me sometimes with the development of the plans." - She was unable to explain why client #3, #4 and #5 did not have strategies and interventions addressing their elopement behaviors. - She acknowledged clients being placed in the hospital and Detention Center for escalating behaviors and returning back to the facility without any new strategies and interventions. - She acknowledged being aware of client #4 running away from the facility and getting to his father's home approximately 3 hours away. "He told us that [former staff #1] transported him not a stranger." During an interview on 1/30/2020 the Director of Operations stated: - He acknowledged the elopement behaviors of clients #3, #4 and #5. - He acknowledged having a high frequency of elopement incidents over the past 5 months where the clients repeatedly ran away from both facility's operated by the agency. In addition, he acknowledged having IVC (Involuntary Commitment) incidents without any changes to clients interventions nor strategies, however; he agreed that there should be goals in each clients PCP plan to address their behaviors of elopement. - No increase of staffing to address the clients behaviors. - They had weekly staff meetings with the License Professional, Qualified Professional, Program Manager to discuss clients behaviors. - "We usually call the police when the guys run away from the facility. If they return back to the facility within approximately 30 minutes on their	V 112		

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V 112	Continued From page 9 own, then we will not call the police." "When they return from the hospital we just process with them to make sure they are ok. The [LP] (License Professional) checks on the clients progress while they are in the hospital, however; no proactive coordination with the hospitals after a IVC discharge to discuss treatment strategies for the clients once they return back to the facility. - He confirmed strategies and interventions to address client #1 and #2's elopement behaviors of elopement should have been written in the PCP (Personal Centered Plan). This deficiency is crossed referenced into 10A NCAC 27G., .1701 Scope, Tag V-293 for a Type A1 rule violation.	V 112		
V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall	V 293		

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V 293	Continued From page 10 require the following: (1) removal from home to a community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care. This Rule is not met as evidenced by: Based on record review and interviews the facility staff failed to provide continuous supervision for 3 of 3 (#3, #4, and #5) clients to ensure safety and minimize the occurrence of behaviors related to elopement.	V 293		

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V 293	Continued From page 11 Cross Reference: 10A NCAC 27G .0205 Assessment and Treatment/Habiltation or Service Plan, Tag V-112. Based on observation, record reviews and interviews the facility failed to develop and implement strategies to address elopement affecting three of three current clients (#3, #4, and #5). Cross Reference: 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUTTag V-537. Based on record reviews and interviews, the facility failed to ensure that one of one staff (#1) demonstrated the competence to use physical restraints techniques for one of one clients (#4). Review on 1/31/2020 of the facility's Plan Of Protection written by the Licensee dated 1/31/2020 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Beginning immediately, we will implement a new protocol as it relates to our clinical oversight of the agency. The new protocol will begin when a referral is made to our program. When a referral is received it will be forwarded to ALL members of the Management Team. The Management Team consists of the Owner of the Company, Director of Operations, Clinical Director/LP, Qualified Professional, Program Director, House Managers, and Lead Residential Advisor. The Management Team will review the clinical information received. Each member of the team will communicate via email their decision as to whether they feel the referral can be served by the agency. The Clinical Director/LP and Qualified Professional will lead this effort. If all members of the team do not feel the referral can be served by the agency, then the Clinical Director/LP and	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-138	A. BUILDING: _____ B. WING _____	01/31/2020

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V 293	Continued From page 12 Qualified Professional will discuss their reasons for denial. If a consensus to admit can't be obtained, then the referral source will be notified of the declination of the referral. If a consensus can be obtained, then the referral source will be notified of the acceptance of the referral. These discussions will be documented on the Clinical Coordination Sheet. Once the referral source is notified of the acceptance of the referral, the Clinical Director/LP and Qualified Professional will develop a clinical plan that reflects strategies to safeguard the consumer upon admission. This clinical plan will also be documented on the Clinical Coordination Sheet. This plan will include but not limited to strategies to keep the consumer safe, goals to be worked on until the Admission Assessment is completed and more defined goals are established, any perceived/special training needs of the staff to ensure they are prepared to treat the consumer upon arrival, and any other pertinent information the Clinical Director/LP and Qualified Professional deems necessary. If there are training needs, then the Clinical Director/LP , Qualified Professional, and the rest of the Management Team will prepare/develop and deliver the training to the staff prior to the consumers arrival. Upon arrival an Admission Assessment will be conducted by the Clinical Director/LP within 24 hours. After this assessment is completed initial treatment goals will be identified for the Person Centered Plan. These treatment goals will become the road map for treatment and will be communicated to staff no later than 7 days after admission. A Person Centered Plan, Crisis Plan, and Consumer Contact Sheet will be placed in the "Shadow Consumer Files" and placed in each facility. This clinical information along with other pertinent information (i.e. Consents, Medicaid Card, Birth Certificates, etc) will be placed in the "Permanent	V 293		

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V 293	Continued From page 13 Consumer File" that will be kept at the LH1 location. The Shadow Files will serve as a "quick reference guide" for the staff to use while treating the consumers. The agency will conduct bi-weekly staff meetings. These staff meetings will be led by the Management Team. Overall clinical treatment and strategies to improve clinical treatment and safeguards for the consumers will be a part of the agenda. The Management Team will solicit input from the direct care staff on strategies to improve clinical treatment for each consumer. Any identified training needs of the staff to assist with better safeguarding the consumers will be discussed and developed by the Clinical Director/LP and Qualified Professional. Once identified training needs are developed, the Clinical Director/LP and Qualified Professional will lead the training delivery with the assistance of other members of the Management Team. This will occur at every staff meeting deemed appropriate. If it is determined that training is needed in between staff meetings then the Clinical Director/LP, Qualified Professional, and other members of the Management Team will develop and deliver the necessary training when required. The Clinical Director/LP will conduct therapy twice per week (total of 4 hrs. per week) to each consumer. If required, the agency will identify an additional LP to assist the Clinical Director/LP and Qualified Professional with therapy delivery and Crisis Management. The Qualified Professional will conduct groups twice per week (total of 4 hrs. per week) to each consumer. The Clinical Director and Qualified Professional will meet weekly to discuss their therapy and group sessions. As a result of this meeting if there are identified changes to be made to treatment deliver, treatment goals, staff training, etc. then	V 293		

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V 293	Continued From page 14 the rest of the Management Team will be notified and those changes will occur. The overall Management Team will meet twice per week to discuss the clinical service delivery of the agency as well as other pertinent needs of the agency. The Management Team will meet on a bi-weekly basis with the consumers at each location. During that meeting the consumers will be given an opportunity to express how they feel their treatment is going. They will also be asked to give feedback regarding any changes they would like to see made within the program. They will have an opportunity to share if they are having issues with any staff member. All information obtained from this meeting will be used to make any necessary treatment and staff adjustments to safeguard the consumers. If any adjustments are necessary then they will be communicated to the staff members and implemented as soon as possible. Our ultimate goal is to ensure the safety of all of our persons served. We feel that by implementing the steps listed above our agency will be better positioned to safeguard the persons served that are entrusted in our care." Based on record reviews client #3, #4, and #5 ran away from the facility 14 times between January 2019 through January 2020. Each client had a history of elopement prior to admission. Staff failed to consistently address clients elopement behaviors and would call 911 to assist as a form of intervention. The incidents escalated to the point of police taking clients to be IVC. After each IVC the clients were released back to the facility with no strategies and interventions to address their behaviors. In addition, the facility made no attempts to meet with the hospital to discuss aftercare plans for the clients. The facility failed to address continued elopements after being	V 293		

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V 293	Continued From page 15 discharged from the hospital. The facility's did not put any interventions or strategies in place to address client #3, #4, and #5's elopement behaviors. This deficiency constitutes a Type A1 violation for serious neglect and must be corrected within 23 days. An administrative penalty of XXXXX is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500 per day will be imposed each day the facility is out of compliance beyond the 23rd day	V 293		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating	V 537		

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V 537	Continued From page 16 the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for	V 537		

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V 537	Continued From page 17 at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures.	V 537		

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V 537	Continued From page 18 (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers.	V 537		

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V 537	Continued From page 19 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that one of one staff (#2) demonstrated the competence to use physical restraints techniques for one of three clients (#4). The findings are: Review on 1/24/2020 of client #4's record revealed: - Admission date of 7/15/19. - Diagnoses of Post Traumatic Stress Syndrome, Oppositional Defiant Disorder, and Reactive Attachment Disorder Review on 1/28/2020 of the facility's records revealed: - "No written documentation explaining the details of the incident. During an interview and observation on 1/29/2020 client #4 stated: -" [Staff #2] punched me in the face recently because I refused to give up my cellphone. One of the female staff called [staff #2] he was working at the other group home. He came to the house I was at and tried to take my phone. I refused to give it to him so he pushed me and grabbed me. We fell onto the floor and my head hit the floor causing the leftside to be cut". - Surveyor observed a discolored scar on the left side of client #4's forehead. It was approximately the size of a 25 cent coin in diameter. - "No other staff nor other clients witnessed the incident. It occurred in the living room area." - Surveyor asked client #4 where was the other clients and staff at the time of the incident and he stated, in the other clients room assisting them.	V 537		

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V 537	Continued From page 20 Review on 1/24/2020 of staff #2's record revealed: -Hire date of 5/15/2018. -Position of Lead Staff -Alternative to Restrictive Intervention training was current. During an interview on 1/30/2020 staff #2 stated: - "I received a phone from the staff on duty letting me know that [client #4] had a cell phone. I immediately drove over to facility #2. I asked [client #4] if he had a cellphone, and he responded not anymore I broke it and threw it in the trash just before you got here". - "[Client #4] swung and tried to hit me, so I grabbed him and we both fell onto the floor. - He acknowledged that he did not release the hold even while both he and client #4 was on the floor. - the therapeutic hold last approximately 5 minutes. I held on to [client #4] while on the floor to control his hand to prevent him from hitting me. - He acknowleged client #4 was injured during the therapeutic hold. The injury was on the left left side of client #4's head. - "I'm not sure what his head hit, but it was during the therapeutic hold. We treated the cut with the first aid kit and process the incident. [client #4] went to his room and went to bed. - He acknowledged that he should have released the hold when they fell on the floor. During an interview on 1/30/20 the Director of Operations stated: - He acknowledged hearing about the incident however client #4 ran away from the facility shortly after the incident occurred. - He acknowledged seeing a scar on the left side of client #4's head but didn't realize it resulted from a therapeutic hold.	V 537		

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V 537	Continued From page 21 - He was unsure if the facility had written documentation to support the incident. This deficiency is crossed referenced into 10A NCAC 27G., .1701 Scope, Tag V-293 for a Type A1 rule violation.	V 537		