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V 000	INITIAL COMMENTS A complaint survey was completed on 2/20/20. The complaints were substantiated(#NC160449 and #NC160573). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents.	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision	V 110	DHSR-Mental Health MAR 17 2020 Lic. & Cert. Section	

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V 110	Continued From page 1 plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure staff demonstrated competency for the population served for 6 of 6 audited staff (#1, #2, #3, #4, #5, #6) and 2 of 2 audited former staff(FS#8, FS#9). The findings are: Review on 2/18/20 of personnel records revealed: -staff #1 was hired on 11/19/19 with the job title of Residential Counselor and completed training on 11/23/19 on the topic of sexual behaviors presented by the Licensed Professional(LP) as part of the orientation training; -staff #2 was hired on 7/2/19 with the job title of Residential Counselor and completed training on 7/3/19 on the topic of sexual behaviors presented by the LP as part of the orientation training; -staff #3 was hired on 3/27/18 with the job title of Residential Counselor and completed training on 3/27/18 on the topic of sexual behaviors presented by the LP as part of the orientation training; -staff #4 was hired on 11/9/19 with the job title of Residential Counselor and completed training on 11/6/19 on the topic of sexual behaviors presented by the LP as part of the orientation training; -staff #5 was hired on 5/9/18 with the job title of Residential Counselor and completed training on 5/3/18 on the topic of sexual behaviors presented by the LP as part of the orientation training;	V 110		

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V 110	Continued From page 2 -staff #6 was hired on 10/7/19 with the job title of Residential Counselor and completed training on 10/15-22/19 on the topic of sexual behaviors presented by the LP as part of the orientation training; -FS#8 was hired on 2/20/16 with the job title of Residential Counselor, resigned on 2/1/20 and completed training on 1/24/17 on sexual aggressive behaviors; -FS#9 was hired on 1/16/20 with the job title of Residential Counselor, resigned on 1/24/20 and completed training on 1/20/20 on the topic of sexual behaviors presented by the LP as part of the orientation training. Review on 2/11/20 of client #1's record revealed: -date of admission 6/11/19 with diagnoses of Attention Deficit Hyperactivity Disorder(ADHD), Oppositional Defiant Disorder(ODD), Post Traumatic Stress Disorder(PTSD) and Social Anxiety Disorder; -age 11 years old; -Comprehensive Clinical Assessment(CCA) dated 5/10/19 documented client #1 had been in fostercare since 2013 and was a victim of sexual abuse and neglect. He struggled with bullying other clients, played the victim with peers and struggled with boundaries with peers. He also was impulsive, manipulative and intrusive as well as demonstrated aggressive behaviors; -CCA updated on 10/23/19 documented client #1 was impulsive, had difficulty sleeping and struggled with limitations. Client #1 also had nightmares, frequent flashbacks and exhibited avoidance behaviors. Client #1 refused to comply, was actively defiant and had trouble accepting the word "no;" -letter dated 11/18/19 from an outpatient therapist documented a NMT(NeuroSequential Model of	V 110		

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V 110	Continued From page 3 Therapeutics) Assessment was completed on client #1. The results indicated although client #1 was cognitively bright but emotionally and socially he functioned as a 3-4 years old with areas of severe to moderate dysfunction in attention/tracking, hyperarousal, impulsivity and being able to delay gratification; -treatment plan dated 1/16/20 and updated 1/29/20 documented the following goals: reduce verbal and physical aggression, practice self-control, demonstrate self-soothing techniques, learn to effectively comply with directives from adult authority figures with no more than 3 prompts/redirection, learn to communicate appropriately with adult authority figures, work on resolving past traumatic events to help cope with stressors, demonstrate effective coping skills, have a psycho-sexual evaluation, learn to identify any sexualized behaviors and demonstrate ability to engage in healthy/appropriate relationships. Review on 2/11/20 of former client #5(FC#5)'s record revealed: -admission date of 9/19/19 with diagnoses of ADHD and Disruptive Mood Dysregulation Disorder(DMDD); -discharged on 1/23/20; -11 years of age; -admission assessment information dated 8/9/19 documented FC#5 was in the custody of Social Services and had supervised visits with his birth mother. FC#5 struggled with aggression, change and accepting "no." FC#5 had a history of running away, destruction of property and anger management. FC#5 also was easily overwhelmed and struggled with peer interactions. FC#5 resided in a foster home and his behaviors had increased in the last 2-3 months. FC#5 attacked his fosterparent leaving bruises. His behaviors	V 110		

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V 110	Continued From page 4 were increasing despite ongoing therapeutic interventions; -CCA dated 1/23/19 documented FC#5 was in a foster home and exhibited temper outbursts, aggression and suicidal statements. FC#5 had three prior inpatient psychiatric admissions due to suicidal ideation and aggression. FC#5 had poor insight, impaired judgement, a flat affect and was easily distracted; -CCA updated 10/22/19 documented FC#5 had problems sleeping, had obsessive thoughts and nightmares. FC#5 displayed aggression, anger outbursts, defiance, profanity and elopement. FC#5 struggled with honesty and excessive talking. FC#5 was sexually abused by an individual who lived with FC#5's birth mother and reported physical abuse by his stepfather. FC#5 was removed from his birth parents at the age of 5 years old. FC#5 was easily influenced by peers and had problems making and keeping friends. FC#5 also had issues with change and control of frequent impulses; -treatment plan dated 8/1/19 and updated 1/10/20 documented the following goals: learn to more effectively communicate with peers and adults, increase ability to ask for coping skills, accept "no" and constructive feedback, decrease occassions of instigating peers, reduce verbal and physical aggression, comply with directives, reduce destruction behaviors and decrease elopement. Review on 2/11/20 of an incident report dated 1/23/20 regarding an incident on 1/23/20 at 7:40am revealed the following documented: -staff(FS#8) came on his shift, did his debriefing with night shift staff and started the client room checks; -discovered client #1 standing over behind FC#5 with fully erect penis;	V 110		

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V 110	Continued From page 5 -FC#5 reported client #1 kept asking him to let client #1 perform anal sex; -FC#5 stated he did not want to engage in anal sex but he did not want client #1 angry at him; -an internal investigation was started on the incident. Review on 2/11/20 of roster of staff who worked the date of the incident revealed: -night shift staff for 1/22/20 starting at 6:30pm until 1/23/20 7:00am included staff #1, staff #2, staff #3 and staff #4; -day shift staff for 1/23/20 starting at 6:30am until 1/23/20 7:00pm included staff #5, staff #6, FS#8 and FS#9. Interview on 2/11/20 with FS#8 revealed: -worked day shift at the facility from 6:30am until 7:00pm; -walked up the stairs to the unit, put his breakfast on the table and began his room checks; -staff #6 and FS#9 were present when he arrived on the unit; -client #1 and FC#5 had their door to their shared bedroom only cracked open; -opened the door and observed FC#5 bent over with his pants down; -client #1 was standing behind FC#5 with his pants open and his penis out; -client #1 was trying to penetrate FC#5; -not sure if either client heard the bedroom door open; -turned on the light and asked what was going on; -FC#5 pulled up his pants and stood up; -client #1 stated he was trying to pick up his stuffed animal; -client #1 began to get irate and was screaming and cursing; -asked FC#5 what happened and FC#5 stated client #1 was "trying to stick is d**k in my a**;"	V 110		

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V 110	Continued From page 6 -took FC#5 out of the bedroom and had FC#5 sit beside him; -called administration and reported the incident immediately; -FC#5 stated client #1 pressured him to do it; -FC#5 stated client #1 asked him every night to engage in sexual behaviors; -FC#5 stated it had happened four times including this incident but was not able to give any dates or times; -FC#5 stated he was not scared of client #1 but did not tell because he did not want client #1 to get in trouble; -accompanied FC#5 to the local emergency room for assessment; -never observed any prior sexual behaviors between FC#5 and client #1; -client #1 and FC#5 had been roommates for about a month; -when client #1was confronted about any behaviors, he blamed others for his actions; -the rule on the unit dictated clients were not allowed to close their bedroom doors all the way if they had a roommate; -room checks were completed every 12-15 minutes and documented in the night sleep log; -not heard any complaints from any other peers about any sexual behaviors regarding client #1 or FC#5; -prior to this incident, observed client #1 rub another peer's leg with a stuffed animal but had not observed anything else inappropriate. Interview on 2/13/20 with FS#9 revealed: -worked the day shift and arrived for shift at 6:30am on 1/23/20; -only worked at the facility for two days; -went upstairs to the unit upon his arrival; -two night shift staff were on the unit(did not recall their names);	V 110		

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V 110	Continued From page 7 -a couple of the clients were up; -all the doors were open when he arrived on the unit; -client #1 and FC#5 were in their beds and appeared to be sleeping; -went downstairs to use the bathroom and then went back upstairs to the unit; -FS#8 had already caught client #1 and FC#5 engaged in sexual activity; -FS#8 relayed the information to him when he returned to the unit. Interview on 2/17/20 with staff #6 revealed: -started work at the facility in 2019; -worked at the facility day shift from 6:30am-7:00pm; -did not remember any training in sexualized behaviors; -schedule included once entered onto the unit, staff completed room checks and started waking up clients at 8:00am; -from 8:00am-9:00am clients completed hygiene and breakfast then went to school at 9:00am; -was on the other side of the unit from client #1 and FC#5's room dealing with client #5 when FS#8 found client #1 and FC#5 engaged in sexual act; -did not remember which staff were on the unit when he arrived on the unit the morning of the incident; -client #1 and FC#5 played with each other; -had not observed any type of sexual behaviors between client #1 and FC#5 prior to the incident; -sometimes FC#5 tried to close the door to his and client #1's room during shift change but staff told him he was not allowed to close the door; -had to open the door to their room at times when FC#5 tried to shut the door; -client #1 and FC#5 liked to play "house" with each other;	V 110		

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V 110	Continued From page 8 -client #1 and FC#5 stated they were playing "house" and playing "mom and dad;" -FC#5 said he was also a vampire and then turned into a werewolf at the full moon; -not heard of client #1 and FC#5 playing a game called "vampire;" -had a meeting after the incident about increased supervision and the incident between client #1 and FC#5. Interview on 2/11/20 with staff #1 revealed: -worked the night shift from 6:30pm-7:00am; -worked with staff #2, #3, #4 the date of the incident; -client #1 and FC#5 always wanted to close their bedroom door; -always told them "no" and they were not allowed to close their bedroom door; -client #1 and FC#5 always played together; -did not observe any sexual behaviors between client #1 and FC#5; -was not aware of the incident until afterwards; -was going out the door off work and met FS#8 coming into work; -only knew client #1 and FC#5 wanted to close their door. Interview on 2/13/20 with staff #2 revealed: -worked the night shift from 6:30pm -7:00am; -did not observe any sexualized behaviors between client #1 and FC#5; -both client #1 and FC#5 slept through the night of 1/22/20; -both were asleep when he got off work the morning of 1/23/20; -did his 15 minute bed check right before he went off shift; -client #1 and FC#5 were asleep during his last bed check; -the night of 1/22/20, client #1 and FC#5 did not	V 110		

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V 110	Continued From page 9 try to close their bedroom door; -had to tell client #1 in the past to leave his bedroom door open; -was off shift before the incident occurred; -had a meeting after incident regarding increased supervision. Interview on 2/17/20 with staff #3 revealed: -worked at the facility from 6:30pm-12:00am; -clients have bedtime at 9:00pm and lights were out; -did 15 minute bed checks; -if two clients were in a bedroom, bedroom door always remained open; -client #1 and FC#5 played together; -never heard of client #1 and FC#5 playing a "vampire" game or" house;" -never observed any sexualized behaviors between client #1 and FC#5; -had a meeting after the incident to discuss what happened and supervision issues. Interview on 2/19/20 with staff #4 revealed: -worked the night shift on 1/22/20; -client #1 and FC#5's door remained open all night; -did not remember client #1 or FC#5 trying to close their door during his shift on 1/22/20; -never observed any sexual behaviors between client #1 and FC#5; -no knowledge of any sexual behaviors between client #1 and FC#5; -no knowledge of client #1 and FC#5 playing the "vampire" game and "house." Interview on 2/11/20 with staff #5 revealed: -worked the day shift 6:30am-7:00pm; -worked as Lead staff on this shift; -client #1 and FC#5 had been roommates for about a month;	V 110		

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V 110	Continued From page 10 -FC#5 switched roommates a lot due to his behaviors and conflict with peers; -came into work on the morning of 1/23/20; -went upstairs, entered the unit and found client #1 and FC#5 already awake; -client #1 asked her can he shut his door and she told him "no;" -client #1 was in his bed and FC#5 was at his bedroom door; -after she told both clients they were not allowed to shut their door, FC#5 got back in his bed; -staff #6 and FS#9 were on the unit when she left to go back downstairs; -she met FS#8 coming up the back stairs to go to the unit as she came down the back stairs; -the 4 night shift staff(staff 1, #2, #3 and #4) were already off shift and had left the facility; -she went through the kitchen, up the front stairs and back on the unit; -found FC#5 sitting with FS#8; -FC#5 told her, "[client #1] was trying to stick his d**k in my a**;" -client #1 was very irate and called FS#8 a liar; -client #1 denied everything and said FS#8 was laying; -client #1's normal response to confrontation regarding a behavior was to yell, scream, cuss and call staff liars; -prior to the incident, noticed client #1 tried to horseplay and touched his peers but never in a sexual way; -never observed any sexual interaction between client #1 and FC#5; -had a staff meeting afterwards to discuss the incident and supervision. Interview on 2/18/20 with staff #7 revealed: -worked night shift 6:30pm-7:00am; -lead staff on night shift; -bedroom doors were always supposed to be	V 110		

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V 110	Continued From page 11 open; -client #1 and FC#5 wanted to shut their bedroom door to play "house;" -started playing this game after they had been roommates for awhile; -was told by staff they were not allowed to shut their door; -client #1 and FC#5 never did explain the game '"house" to him; -client #1 and FC#5 got upset when they were not allowed to shut their bedroom door; -client #1 and FC#5 liked to play another game together but did not remember what it was called; -other peers on the unit picked on client #1 and FC#5 for playing the "house" game; -peers asked client #1 and FC#5 "what you trying to do, try to suck his d**k?" -"Peers hitting them hard with that;" -prior to the incident, was debriefed by day shift staff about the games client #1 and FC#5 were playing together; -not aware if the information about the the games were related to the LP; -was told to keep a close eye on all clients. Interview on 2/18/20 with the LP revealed: -provided individual and group therapy to both clients until 12/2019; -another therapist saw both clients starting in 12/2019; -sometimes client #1 and FC#5 refused to engage in therapy; -FC#5 had disclosed his past sexual abuse but had not acted out sexually at the facility; -both client #1 and FC#5 talked about the "vampire" game; -talked about this game in FC#5's Child and Family Team meeting(CFT Mtg); -FC#5 talked about playing "house " with client #1 at his last CFT Mtg prior to the incident;	V 110		

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V 110	Continued From page 12 -FC#5 reported he played "house" with his birth mother and brother in the past; -was not able to get details about the game "house" from FC#5; -set up a time to have a session with FC#5 regarding the "house" game on 1/22/20 prior to the incident but FC#5 refused therapy on 1/22/20; -client #1 never brought up the "house" game in therapy; -understood both clients played together with their stuffed animals; -both played the "vampire" game with their stuffed animals; -pretended their stuffed animals chased each other and bit each other; -felt this play was very age appropriate considering at what level both clients were developmentally; -at FC#5's last CFT Mtg, discussed possible room changes; -FC#5 and client #1 did not want to be separated as roommates; -did not see any sexual behaviors during their play together; -did not feel there were sexual behaviors between client #1 and FC#5. Review on 2/18/20 of therapy documentation for client #1 and FC#5 from 11/1/19-1/23/20 revealed: -individual and group sessions for both clients; -no documentation of any inappropriate touching/sexualized behaviors, poor boundaries or the games "vampire or "house" addressed in sessions with client #1; -no documentation of any inappropriate touching/sexualized behaviors, poor boundaries or the games "vampire or "house" addressed in sessions with FC#5 with the exception of some discussion of his history of sexual abuse.	V 110		

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V 110	Continued From page 13 Interview on 2/11/20 with client #1 revealed: -been at the facility since 6/2019; -used to share a bedroom with FC#5; -FC#5 was not good and "he kept doing stuff;" -did not remember "what he(FC#5) did;" -played "vampires" with FC#5 with their stuffed animals; -used the mouse and the dog; -the mouse would bite the dog on the neck; -he thought up the game "vampires;" -his older brother taught him how to play the game; -he and his brother chased girls outside and bit the girls on the neck; -he and his brother carried the girls upstairs to his mother's bedroom; -they threw the girls on the floor and the bed; -nothing else happened; -FC#5 made him feel uncomfortable; -he was in his room with FC#5; -he asked staff #6 was it time to get up and staff #6 said a few more minutes; -his sweatpants fell down while he was cleaning his room; -was trying to find his stuffed bear; -FC#5 kept pushing him so he was not able to get out of his room to tell staff; -FC#5 put his rear in client #1's face and expelled gas which made him feel uncomfortable; -client #1 reported he asked FC#5 to stop; -FS#8 came in their room and client #1's pants were down; -FC#5 said client #1 was being inappropriate with him; -client #1 told FS#8 nothing happened and FC#5 lied; -FC#5 tried to shut their door when staff was not looking; -FC#5 wanted to shut the door and play the	V 110		

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V 110	Continued From page 14 "vampire" game with client #1; -every night FC#5 tried to shut their door and tried to wake client #1 up at night; -denied any inappropriate touching between him and FC#5; -staff did not know about the "vampire" game. Interview on 2/17/20 with FC#5 revealed: -liked client #1 "sometimes;" -client #1 tried to shut the door to their room; -staff caught them and told them to open it back up; -client #1 kept him awake at night; -played "vampires" with client #1; -client #1 was already bitten by the werewolf and the vampire; -client #1 would "fake bite" FC#5 on his neck and he became a werewolf; -played "house" with client #1; -client #1 was the dad and he was the mom; -they got married and fell in love; -"not really kiss each other, that would be gross, not kiss a boy;" -before he and client #1 fell in love, client #1 was the boyfriend and he was the girlfriend; -was bending over the pick up something and client #1 pulled down his pants; -"stuck his d**k up my a**;" -client #1 had the door closed to their room; -FS#8 opened the door; -took him to the hospital; -never happened before this time. Interview on 2/13/20 with FC#5's legal guardian revealed: -had a CFT Mtg on 1/10/20; -issues regarding inappropriate touching and poor boundaries between client #1 and FC#5 was brought up in the meeting; -discussion about client #1 and FC#5 closing their	V 110		

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V 110	Continued From page 15 door to their bedroom and why did they try to close it; -asked FC#5(who was present at the CFT Mtg) about why he and client #1 were trying to close their door; -he responded they were playing the "vampire" game; -talked about her concerns about this and option to separate client #1 and FC#5; -was informed client #1 and FC#5 did not want to move; -talked about either move FC#5 to another room or monitor more as she was concerned about the interaction between client #1 and FC#5; -on 1/22/20 received a call from the administrative assistant regarding a restraint involving FC#5; -asked administrative assistant was FC#5 moved out of room with client #1 or monitored more; -next day on 1/23/20 was notified of the sexual behavior between client #1 and FC#5; -discharged FC#5 that day from the facility. Review on 2/18/20 of the CFT Mtg documentation dated 1/10/20 for #FC#5 revealed: -no documentation of discussion regarding inappropriate touching between client #1 and FC#5; -no documentation of discussion regarding poor boundaries between client #1 and FC#5; -no documentation of separating client #1 and FC#5 as roommates; -no documentation of increasing monitoring of the interaction between client #1 and FC#5. Review on 2/18/20 of staff supervision from 9/2019-1/2020 revealed: -no documentation of discussion with staff about concerns with client #1 and FC#5's interactions; -no documentation of discussion regarding client	V 110		

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V 110	Continued From page 16 #1 and FC#5's games of "vampire" and "house;" -no documentation of discussion to increase supervision to address concerns regarding client #1 and FC#5's interactions. Review on 2/18/20 of an email sent to all staff from the Residential Supervisor revealed the following documented, "Staff, it is very important that all consumer doors are open at ALL times and we are constantly doing room checks." Interview on 2/18/20 with the Program Director and Residential Supervisor revealed: -already had a staff meeting/training scheduled for 2/7/20; -added supervision issues to the topics covered with staff; -discussed with staff increasing supervision , monitoring clients at night every 15 minutes, ensuring doors were open and lights were on in the commons area of the unit. This deficiency is cross referenced into 10 A NCAC 27G .1901 Psychiatric Residential Treatment for Children and Adolescents Scope V314 and must be corrected within 45 days.	V 110		
V 314	27G .1901 Psych Res. Tx. Facility - Scope 10A NCAC 27G .1901 SCOPE (a) The rules in this Section apply to psychiatric residential treatment facilities (PRTF)s. (b) A PRTF is one that provides care for children or adolescents who have mental illness or substance abuse/dependency in a non-acute inpatient setting. (c) The PRTF shall provide a structured living environment for children or adolescents who do	V 314		

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V 314	Continued From page 17 not meet criteria for acute inpatient care, but do require supervision and specialized interventions on a 24-hour basis. (d) Therapeutic interventions shall address functional deficits associated with the child or adolescent's diagnosis and include psychiatric treatment and specialized substance abuse and mental health therapeutic care. These therapeutic interventions and services shall be designed to address the treatment needs necessary to facilitate a move to a less intensive community setting. (e) The PRTF shall serve children or adolescents for whom removal from home or a community-based residential setting is essential to facilitate treatment. (f) The PRTF shall coordinate with other individuals and agencies within the child or adolescent's catchment area. (g) The PRTF shall be accredited through one of the following; Joint Commission on Accreditation of Healthcare Organizations; the Commission on Accreditation of Rehabilitation Facilities; the Council on. Accreditation or other national accrediting bodies as set forth in the Division of Medical Assistance Clinical Policy Number 8D-1, Psychiatric Residential Treatment Facility, including subsequent amendments and editions. A copy of Clinical Policy Number 8D-1 is available at no cost from the Division of Medical Assistance website at http://www.dhhs.state.nc.us/dma/. This Rule is not met as evidenced by: Based on records review and interviews, the	V 314		

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V 314	Continued From page 18 facility failed to ensure supervision and specialized interventions on a 24-hour basis and failed to ensure therapeutic interventions addressed functional deficits affecting 4 of 4 current clients (#1, #2, #3, #4) and 1 of 1 former client(FC#5). The findings are: Cross Reference: 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals V110 Based on records review and interviews, the facility failed to ensure staff demonstrated competency for the population served for 6 of 6 audited staff (#1, #2, #3, #4, #5, #6) and 2 of 2 audited former staff(FS#8, FS#9) Interview on 2/18/20 with client #1 revealed: -night shift staff brought "stuff in from their houses and start playing it;" -night staff played video games; -brought their own television to watch also; -all happened at night; -in the morning, the video games and televisions were gone. Interview on 2/18/20 with client #2 revealed: -night shift staff brought the television upstairs and watched it during their shift; -seen some staff on their cell phones. Interview on 2/18/20 with client #3 revealed: -night shift staff sometimes were watching television; -sometimes staff #7 brought in his video game system and staff played on it. Interview on 2/18/20 with client #4 revealed: -night shift staff brought in their video game system and played them; -night shift staff brought in their own television to watch.	V 314		

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V 314	Continued From page 19 Interview on 2/18/20 with staff #7 revealed: -worked night shifts 3-4 days a week; -used to bring in video games; -played a couple times after 12 midnight; -playing video games helped staff to try to stay awake; -watched television also; -rule was staff cannot have cell phones on the unit. Interview on 2/18/20 with staff #3 revealed: -worked night shift 6:30pm-7:00am; -played video games after clients went to sleep; -watched television after clients went to sleep. Interview on 2/20/20 with the Program Director and the Quality Management Director revealed: -had addressed the night shift playing video games prior; -not aware they were still playing video games; -Residential Supervisor and the Program Director had started "pop ups" during night shift to ensure client supervision by staff; -did not have documentation of the "pop ups;" -have staff #7 as a Lead staff on night shift 3-4 days a week; -other Lead staff on night shift resigned several months ago and was in the process of trying to hire a replacement; -in the interim, the Residential Supervisor worked a split shift and was at the facility until 9pm-10pm on the nights staff #7 did not work; -want to obtain a special trainer on sexualized behaviors to train more in depth in this area; -will ensure all areas of concern will be addressed. Review on 2/20/20 of the Plan of Protection dated 2/20/20 and completed by the Program Director	V 314		

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V 314	Continued From page 20 revealed the following documented: -"What immediate action will the facility take to ensure the safety of the consumers in your care? A staff meeting is scheduled for tomorrow Friday 2/21/20. Plans to discuss concerns of current allegations, talk about red flags and triggers and discuss supervision for kids. Staff will be informed of new forms(po-up visit) from Supervisor/Program Director, Clinical Director etc. The new rule is that all bedroom doors open and main floor light remain on. Program Director will seek additional training in sexualized behavior knowing red flags and some triggers;" -Describe your plans to make sure the above happens. Staff supervisor will increase individual supervision to new staff(Residential Counselors) discussion about night duties and red flags and not playing video games. Pop up visits will be done and documented for night shift staff. Training will be scheduled to increase staff skills and ongoing training." Client #1 had a diagnoses of Attention Deficit Hyperactivity Disorder(ADHD), Oppositional Defiant Disorder, Post Traumatic Stress Disorder and Social Anxiety Disorder. Client #1 was a sexual abuse victim and struggled with physical boundaries with peers as well as impulsivity and manipulation. FC#5 had a diagnoses of Disruptive Mood Dysregulation Disorder and ADHD. FC#5 was a sexual abuse victim, easily influenced by peers and also struggled with impulsivity. On 1/23/20 during the transition between the facility's night shift and the day shift, client #1 and FC#5 were discovered by former staff#8 in their bedroom engaging in sexual behaviors with their bedroom door almost shut. Prior to the sexual encounter between client #2 and FC#5, there were indications of suspicious interaction between client #1 and FC#5 including	V 314	Staff random "Pop- Up" form has been developed and implemented. Staff Supervisor/Program Director/Clinical Director but not limited to appointed staff, will be responsible for documenting on form. The form documents (Staff conducting pop up visit/Time/Date/Staff Present/any issues(s) needing to be addressed). -QP level staff has been hired and is in training to work on night shift to assist with interventions and staff supervision Clinical Director coordinated -Sexualize Behavioral Training scheduled for March 26, 2020 from 10am to 3pm. This training will be facilitated by Child Advocacy Center -Butterfly House of Stanly County and will be held in the conference room at the Sleep-Inn Hotel, Albemarle, NC.	3/2/20 and ongoing 3/26/20- training date

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V 314	Continued From page 21 both clients desire to always be together, wanting to close their bedroom door to play together and certain games of playing "vampires" and "house." All staff had been trained in sexualized behaviors at employment orientation but failed to recognize the red flags demonstrated by client #1 and FC#5's interactions. Also, some staff were not even aware of these behaviors and games of client #1 and FC#5. Night shift staff also played video games and watched television during their shift. The lack of staff competence and lack of supervision was detrimental to the health, safety and welfare of the clients and constitutes a Type B rule violation which must be corrected within 45 days. If this violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for every day the facility is out of compliance beyond the 45th day.	V 314		