Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDIEAN	or dorate of the transfer of t	BENTI IOATION NOMBER.	A. BUILDING: _		OOWII EETEB
		MHL014-080	B. WING		C 06/16/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
CALDWEL	L DAY TREATMENT		DLEY SHOALS F FALLS, NC 28		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 000	INITIAL COMMENTS	;	V 000		
	The complaint was su #NC00165106). A de This facility is license category: 10A NCAC	officiency was cited.  Indicated for the following service and are constant of the following service and for the following services. The following services with Emotional or the following services.			
V 110	27G .0204 Training/S Paraprofessionals	Supervision	V 110		
	SUPERVISION OF P  (a) There shall be not paraprofessionals.  (b) Paraprofessional associate professional associate professional professional associate professional aspopulation served.  (d) At such time as a employment system in the qualified professional associate professionals shall de (e) Competence shall exhibiting core skills in technical knowled (2) cultural awarened (3) analytical skills;  (4) decision-making (5) interpersonal skills (6) communication served (7) clinical skills.  (f) The governing bodevelop and implementations in the parameters of the parame	ified in Rule .0104 of this s shall demonstrate d abilities required by the a competency-based is established by rulemaking, sionals and associate emonstrate competence. Ill be demonstrated by including: including: inse; its;			

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		MHL014-080	B. WING		06	C 5/ <b>16/2020</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
CALDWE	LL DAY TREATMENT	1889 DL	IDLEY SHOALS RO	AD		
		GRANIT	E FALLS, NC 2863	0		
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 110	Continued From pag	e 1	V 110			
	plan upon hiring eacl	h paraprofessional.				
		iew and interview, the facility				
	failed to ensure 1 of 1 former paraprofessional staff (Former Staff #1) maintained their					
	professional boundar population served. T	ries required for the				
	Review on 5/19/20 of FC #1's record revealed: -he was 16 years old and was admitted on 7/16/19;					
	-his diagnoses includ Hyperactivity Disorde mental health service	er (ADHD), Encounter for				
	non-parental child ab	ouse, and Intermittent				
	Explosive Disorder; -his 1/2/20 treatment	plan included work on				
	learning and practicing	ng appropriate boundaries staff strategy to provide him				
		lationship that supported his				
	-he was discharged	on 1/6/20.				
	Review on 5/22/20 o revealed:	f Current Client #9's record				
	-he was 14 years old -his diagnoses includ	and was admitted on 2/7/19; led Oppositional Defiant nduct Disorder, ADHD,				
	Persistent (Chronic)	Motor or Vocal Tic Disorder, with Depressed Mood;				
	_	nt plan included work on				
		ng appropriate boundaries staff strategy to provide him				

Division of Health Service Regulation

STATE FORM 6899 P7ZW11 If continuation sheet 2 of 9

Division of	Division of Health Service Regulation					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		SURVEY ETED	
MHL014-080 B. V		B. WING		06/1	6/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ITE, ZIP CODE		
CALDWE	LL DAY TREATMENT		LEY SHOALS F FALLS, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 110	with a therapeutic relatereatment plan;  Review on 5/20/20 of personnel record revershe was hired 3/11/1 position as a day treather training for her programmer of the program	ationship that supported his  Former Staff (FS #1)'s ealed: 9 in a paraprofessional tment youth counselor; osition included: vision and Management of blem Sexual Behavior and raining;" on "Counselor's Orientation on code of ethics and ies; ed on 2/28/20 due to formance; received verbal and n: 10/15/19 (verbal) 10/28/19 repervision on professional (verbal and written sional boundaries), and hary warning); vritten warning on 12/31/19 his with professional disciplinary notice dated	V 110			

Division of Health Service Regulation

Review on 5/20/20 of a written statement of a meeting, which was dated 2/20/20, and included Client #9 and the Program Director revealed:
-Client #9 made statements about his interactions

-they hugged on 2/17/20 and FS #1 asked him on 2/18/20 to keep their hugging a secret and not to tell the Lead Case Manager (CM)/Qualified Professional (QP), who was her supervisor;

with FS #1 which included:

STATE FORM P7ZW11 If continuation sheet 3 of 9

Division of Health Service Regulation

DIVISION	n nealth Service Regu	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					C
		MHL014-080	B. WING	<del></del>	06/16/2020
NAME OF B		OTDEET AD	DEGG OITY OTA	TE 710 000E	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	,	
CAI DWFI	L DAY TREATMENT	1889 DUD	LEY SHOALS F	ROAD	
0,(251121		GRANITE	FALLS, NC 28	630	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE
				DEFICIENCY)	
V 110	Continued From page	3	V 110		
		en he sat close to her;			
	-she followed his re-	quests to take his hoodie			
	(sweatshirt), underwe	ar and socks to her home to			
	wash;				
	-she allowed him to	change clothes in the closet			
	of one of the classroo	_			
		othing items (shoe strings)			
	she had not gotten for	- , - ,			
	<u> </u>	e interactions with FS #1			
	started after another				
	identified, left the day	treatment program.			
	Davious on E/20/20 of	written handwritten netes			
		written handwritten notes			
		the licensee on 5/19/20			
	revealed:				
		ated a meeting was held			
		led the Program Director,			
	-	pordinator, and Human			
	Resources Director;				
	-this entry indicated the	nat FS #1 admitted to			
	actions that included	allowing Client #9 to change			
	his clothes at day trea	atment and an admission to			
	having took and wash	ned Client #9's and FC #2's			
	clothes at her home.				
	Review on 5/20/20 of	a Level 1 written incident			
	report for FC #1 revea	aled:			
	-the report was compl	leted by FC #1's residential			
		signed by her on 2/29/20;			
		s identified as "inappropriate			
	boundaries;"				
	·	osed in a 2/14/20 CFT			
		m meeting) that FC #1 had			
	`	none since 12/2019 and was			
		ult (FS #1) that the mother			
	•	,			
		support for FC #1 in his life			
	but the texting gave h	ier red liags.			
		::1 50 !!4			
	Interview on 6/11/20 v	with FC #1 revealed:			

Division of Health Service Regulation

-when he first started the program in 7/2019, FS

STATE FORM 6899 P7ZW11 If continuation sheet 4 of 9

Division (	of Health Service Regu	lation			FORM	APPROVED
STATEMENT OF DEFICIENCIES (X1) PR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S	
		MHL014-080	B. WING		06/1	) 16/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
041 5145		1889 DU	DLEY SHOALS R	ROAD		
CALDWEI	LL DAY TREATMENT	GRANIT	E FALLS, NC 286	630		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 110	Continued From page	e 4	V 110			
	-she told him not to te although he knew hug-she bought him 2 "ho hoods), 3 pairs of par several packs of gum-he and FS #1 "convewritten notes, in which as "I love you" and FS she was thinking abordhe was instructed by away her notes, which after having read there he had an "unhealthy which continued after program and he and I messages and calls the used his mother's messages and calls vehis mother aware of #1; -his mother disclosed	ed her arms and hugged him; ell anyone about their hug gging was wrong; coodies" (sweatshirt with ents, 1 pair of shoes, and and any ersed frequently" through the wrote such statements and should be such statements and the wrote him notes that the state of the did in the restroom ents, and the did in the restroom ents, and the left the day treatment and the state of				

Interview on 6/11/20 with Client #9 revealed: -he knew FS #1 as a former staff in his day

-he has had no further contact with FS #1 since

treatment program;

-she "did a lot of nice stuff for us kids," (brought in

this disclosure.

doughnuts and supplies (pencils) into the classroom);

-she did a favor for him by taking his hoodie to her home and washed it for him;

-she hugged him once and she told him not to tell anyone;

-she did not want him to tell about the hug so he would not get into trouble;

Division of Health Service Regulation

STATE FORM 6899 P7ZW11 If continuation sheet 5 of 9

Division of	Division of Health Service Regulation					
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	Y
		MHL014-080	B. WING		C <b>06/16/202</b>	20
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
CALDWE	L DAY TREATMENT	1889 DU	DLEY SHOALS F	ROAD		
OALDWLI	LE DAT TICLATMENT	GRANITI	FALLS, NC 28	630		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COM	(X5) MPLETE DATE
V 110	Continued From page	e 5	V 110			
		ed work on developing elationships, and solving				
	(a paraprofessional program from 3/2019 -her job duties include the day treatment prosupport system to the -FC #1 wrote and gav was thinking about he did not think about the -after FC #1 left a not said he loved her, a not week with her, her su Manager (CM)/Qualific Quality Improvement therapists; -she was told at this reshe had boundary iss #1), she was told not supplies into the class	treatment youth counselor osition) at the day treatment until 2/21/20; ed to help teach life skills to gram clients and to be a clients; we her notes that said he er and he loved her but she er notes as being romantic; e on her desk one time that neeting was held the next pervisor (the Lead Case lied Professional (QP), the				
	and chairs close to he -she did not clearly ur what constituted a pro -she perceived hersel the clients;	er desk; inderstand from this meeting ofessional boundary issue; if as a support system for sed a professional boundary				

Division of Health Service Regulation

washing);

crossed professional boundary;

-she acknowledged she provided "extra support" for the clients who lived in group homes (she bought clothing items and gum for FC #1 and admitted Client #9's sweatshirt to her home for

-after she washed Client #9's sweatshirt, she was

STATE FORM P7ZW11 If continuation sheet 6 of 9

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
7.11.2.1.2.1.1.1			A. BUILDING: _		00 22.125
		MHL014-080	B. WING		C 06/16/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
OAL DIAGE	L DAY TREATMENT	1889 DUD	LEY SHOALS F	ROAD	
CALDWELL DAY TREATMENT GRANITI			FALLS, NC 28	630	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE COMPLETE
V 110	told by the Program E type of thing for the type of thing for the typrogram; -she went through ret review of the program-she had supervision CM/QP around bound (QPs) allowed the clie closer to them and br-FC #1's mother had to be a support systel texted and called him-she received verbal actions for unsatisfactleft her job on 2/21/20 Interview on 5/22/20 revealed: -she directly supervising usual individual clinical supron a monthly basis; -she had meetings with QI Director and therat concerns about her (I (concerns included he staff about FC #1's not clients that were not pallowed clients to gatt desk); -she counseled FS #7 about working on her "blanket statements" boundaries as a remited to the staff about statements and the staff about working on her "blanket statements" boundaries as a remited to the staff about working on her "blanket statements"	Director she could not do this upe of clients served by the raining that included a a d's orientation handbook; meetings with the Lead dary issues while other staff ents to move their desks ought in snacks; encouraged her to continue of for him the reason she county; and written disciplinary tory job performance and downwith the Lead CM/QP and FS #1; ally occurred through ervision and staff meetings the FS #1 that included the pists to discuss staff and the pists to discuss staff and communicating with otes, her buying items for ore-approved, and she her around and sit on her and in individual supervision houndary issues and made in staff meetings on neder to all staff;	V 110	DEFICIENCY)	
	issue with boundaries -other day treatment their concerns about program that they per	e she had a problem or an in her work with clients; staff kept her informed of FS #1's behaviors in the received crossed professional collowed up with FS #1 about			

Division of Health Service Regulation

STATE FORM 6899 P7ZW11 If continuation sheet 7 of 9

Division of	Division of Health Service Regulation						
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL014-080	B. WING		C <b>06/16/2020</b>		
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE ZIP CODE			
			DLEY SHOALS F				
CALDWEL	L DAY TREATMENT	GRANITE	FALLS, NC 28	630			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE		
V 110	Continued From page	e 7	V 110				
	these concerns and dissued; -she was not aware user from the program that texting and calling one.  Interview on 6/16/20 wand Client #9 reveale -she had met in indivision and Client #9 and prospective their interactions with -she did not believe the #1 and Client #9 had significant setbacks in work or caused eithere-although FS #1 receive thics and on profess continued to have both Interviews on 5/18/20 Improvement Directore-5/18/20, FS #1's emptor unsatisfactory job included the knowledget texting and calling a cafter his discharge from -The Program Directions and concerned -6/16/20, FS #1's retrained to the professional boundaries was clear professional boundaries.	ntil after FC #1's discharge the and FS #1 had been e another.  with a therapist for FC #1 discussed with them about FS #1; ne separate interactions FC with FS #1 created in their individual treatment of them distress; ived retraining on code of ional boundaries, she undary issues with clients.  and 6/16/20 with the Quality revealed: ployment ended on 2/28/20 performance, which ge on 2/28/20 of FS #1 client (FC #1) and his mother of the program; etor handled the personnel FS #1; aining on professional in what constituted ies and which included no nots.  with the Program Director dily" and "too chummy" with					
	improper boundary is:						

Division of Health Service Regulation

-FS #1 showed favoritism toward clients (FC #1

STATE FORM 6899 P7ZW11 If continuation sheet 8 of 9

Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER  CALDWELL DAY TREATMENT  1889 DUDLEY SHOALS ROAD GRANTE FALLS, NC 28530  PREFIX (FACILIZATION OR LSC IDENTIFYING INFORMATION)  PREFIX (FACILIZATION OR LSC IDENTIFYING INFORMATION)  V 110  Continued From page 8  and Client #9); -FS #1's favoritism ranged from having been more caring and attentive than she was expected, and buying items like gum, drinks and washing clothes for "some" (FC #, FC #2 and Client #9) clients and not other clients; -She and staff were not aware of FS #1's continued communication with FC #1 until his mother brought up about their texting and calling from her cell phone in a 2/2020 meeting with FS #1's residential Home Manager.		FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER  CALDWELL DAY TREATMENT  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 110  Continued From page 8 and Client #9);  -FS #1's favoritism ranged from having been more caring and attentive than she was expected, and buying items like gum, drinks and washing clothes for "some" (FC #, FC #2 and Client #9) clients and not other clients;  -She and staff were not aware of FS #1's continued communication with FC #1 until his mother brought up about their texting and calling from her cell phone in a 2/2020 meeting with FS							С
CALDWELL DAY TREATMENT  1889 DUDLEY SHOALS ROAD GRANITE FALLS, NC 28630    CAUTHOUSE   CAU			MHL014-080	B. WING		06/	16/2020
CALDWELL DAY TREATMENT  GRANITE FALLS, NC 28630  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 110  Continued From page 8 and Client #9); -FS #1's favoritism ranged from having been more caring and attentive than she was expected, and buying items like gum, drinks and washing clothes for "some" (FC #, FC #2 and Client #9) clients and not other clients; -She and staff were not aware of FS #1's continued communication with FC #1 until his mother brought up about their texting and calling from her cell phone in a 2/2020 meeting with FS	NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE		
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 110  Continued From page 8 and Client #9); -FS #1's favoritism ranged from having been more caring and attentive than she was expected, and buying items like gum, drinks and washing clothes for "some" (FC #, FC #2 and Client #9) clients and not other clients; -She and staff were not aware of FS #1's continued communication with FC #1 until his mother brought up about their texting and calling from her cell phone in a 2/2020 meeting with FS	CALDWEI	LL DAY TREATMENT					
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 110  Continued From page 8  and Client #9);  -FS #1's favoritism ranged from having been more caring and attentive than she was expected, and buying items like gum, drinks and washing clothes for "some" (FC #, FC #2 and Client #9) clients and not other clients;  -She and staff were not aware of FS #1's continued communication with FC #1 until his mother brought up about their texting and calling from her cell phone in a 2/2020 meeting with FS  PREFIX TAG  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  DATE  OMPLETE DATE  OMPLETE CROSS-REFERENCED TO THE APPROPRIATE  CROSS-REFERENCED TO THE APPROPRIATE  DATE  OMPLETE DATE  OMPLETE DATE  OMPLETE DATE  OATE		I		FALLS, NC 286			
and Client #9); -FS #1's favoritism ranged from having been more caring and attentive than she was expected, and buying items like gum, drinks and washing clothes for "some" (FC #, FC #2 and Client #9) clients and not other clients; -She and staff were not aware of FS #1's continued communication with FC #1 until his mother brought up about their texting and calling from her cell phone in a 2/2020 meeting with FS	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI	OULD BE	COMPLETE
	V 110	and Client #9); -FS #1's favoritism ra more caring and atter and buying items like clothes for "some" (For clients and not other -She and staff were not continued communicate mother brought up als from her cell phone in	inged from having been intive than she was expected, gum, drinks and washing C #, FC #2 and Client #9) clients; not aware of FS #1's ation with FC #1 until his bout their texting and calling in a 2/2020 meeting with FS	V 110			

Division of Health Service Regulation

STATE FORM 6899 P7ZW11 If continuation sheet 9 of 9