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V 000	INITIAL COMMENTS A complaint survey was completed on June 23, 2020. The complaints were substantiated (Intakes #NC00165661, #NC00165668). Deficiencies were cited. This facility is licensed for the following service category: 10A 27G .1900 Psychiatric Residential Treatment for Children and Adolescents.	V 000		
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 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.	V 314		

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V 314	Continued From page 1 (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 record review and interviews the facility failed to coordinate getting medical treatment for one of twelve clients (#1). The findings are: Cross Reference: Tag V517-10A NCAC 27E. .0104 Client Rights-Seclusion and Physical Restraint-Based on record reviews and interviews the facility staff failed to use restrictive interventions in a manner that would not cause harm or abuse for one of twelve clients (#1). Review on 6/16/20 of Client #1's record revealed: -Admission date of 3/23/20. -Diagnoses of Disruptive Mood Dysregulation Disorder; Conduct Disorder, Unspecified Onset; Post Traumatic Stress Disorder; Attention Deficit Hyperactivity Disorder (per history); Child Neglect (per record). Review on 6/23/20 of a Plan of Protection	V 314		

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V 314	Continued From page 2 revealed: -Plan was dated 6/23/20. -Written by the Senior Vice President. (1) What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm?: "The facility would conduct a review of the CPI restraint course. Staff will be retrained on restraint policies as well as performing restraints to ensure they understand when to utilize restraints and how to perform them when needed. " (2) Describe your plans to make sure the above happens: "The Executive Director and Senior First Responder will conduct multiple sessions to train staff on restraint policies and the use of restraint within the next 30 days (no later than, 7/25/20.) A sign in log will be maintained to record attendance. Trainers will verbally question and/or ask demonstrations to ensure comprehension." Client #1 had diagnoses of Disruptive Mood Dysregulation Disorder, Conduct Disorder, Unspecified Onset; Post Traumatic Stress Disorder and Attention Deficit Hyperactivity Disorder. Staff #5 and Staff #6 attempted to restrain Client #1 by pulling his arms to the side and trying to get a hold of his hands in a restrictive intervention technique. Client #1, Staff #5 and Staff #6 had fallen to the floor in the failed attempt to restrain Client #1. During the fall Client #1 hit his face on the metal frame corner of the bed consequently suffering a fracture of the left orbital floor of his eye. The facility's Executive Director failed to coordinate medical treatment in a timely manner for Client #1. Client #1 did not receive medical treatment until 4 days after he was injured, when he was taken to the hospital by a Child Protective Service investigator. This deficiency constitutes a Type A1 rule violation for serious harm and must be corrected within 23	V 314		

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V 314	Continued From page 3 days. An administrative penalty of $3,000] is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 314		
V 517	27E .0104(c-d) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (c) Restrictive interventions shall not be employed as a means of coercion, punishment or retaliation by staff or for the convenience of staff or due to inadequacy of staffing. Restrictive interventions shall not be used in a manner that causes harm or abuse. (d) In accordance with Rule .0101 of Subchapter 27D, the governing body shall have policy that delineates the permissible use of restrictive interventions within a facility. This Rule is not met as evidenced by: Based on record reviews and interviews the facility staff failed to use restrictive interventions in a manner that would not cause harm or abuse for one of twelve clients (#1). The findings are: Review on 6/16/20 of Client #1's record revealed: -Admission date of 3/23/20. -Diagnoses of Disruptive Mood Dysregulation Disorder; Conduct Disorder, Unspecified Onset; Post Traumatic Stress Disorder; Attention Deficit Hyperactivity Disorder (per history); Child Neglect (per record).	V 517		

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V 517	Continued From page 4 Review on 6/16/20 of Client #2's record revealed: -Admission date of 4/1/20. -Diagnoses of Unspecified Bipolar and Related Disorder; Conduct Disorder, Adolescent Onset type; Cannabis Use Disorder, Moderate; Child Neglect (per history). Review on 6/16/20 of Staff #5's personnel record revealed: -Hire date of 11/24/19. -He was hired as a Residential Mentor. -He had completed training on Alternatives to Restrictive Intervention and Seclusion, Physical Restraint and Isolation time Out on 10/21/19. Review on 6/16/20 of Staff #6's personnel record revealed: -Hire date of 6/12/15. -She was hired as a Residential Mentor. -She had completed training on Alternatives to Restrictive Intervention and Seclusion, physical Restraint and Isolation time Out on 6/15/19. Review on 6/18/20 of Incident Report revealed: -Report was dated 5/21/20. -On 5/21/20, there was a crisis call made (935) in Suite 2 due to Client #2 having a crisis. -Staff #1 arrived and asked Client #1 if he would sit on his bed in his room while staff was processing with Client #2. -Client #1 refused and became verbally aggressive toward staff and began to threaten staff. -Client #1 pushed staff #5 and hit him in the face and a "High Level Crisis Prevention Institute (CPI) hold" was attempted, but as staff attempted to grab him, Client #1 dropped to the floor hitting the side of his face on his bed frame. -Supporting staff assisted with helping Client #1 up to make sure he was alright.	V 517		

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V 517	Continued From page 5 -Client #1 was walked out of the suite to be assessed by the nurse. -The nurse assessed Client #1. -A large bump was noted to Client #1's left eye with swelling around the eye. -The nurse placed an icepack on Client #1's swelling and gave him an anti-inflammatory medication. -No other findings were noted. Client #1 denied headache, vision disturbances or lightheadedness. -Client #1 had reached "tension reduction" and was able to be walked back to his suite. -No further intervention was necessary. -Debriefing with Client #1: Client #1 stated that he could have stayed in his room and not got involved in what was going on. -Debriefing with Staff #1 and #2: Staff discussed how important it is to move the audience when responding to any potential crisis. -Staff were also referred back to the policy and CPI training on restrictive intervention. Review on 6/18/20 of facility's Internal Investigation Report revealed: -Report was dated 5/26/20. -Investigation was completed by the Vice President of Administration. -Investigation was started because on 5/22/20, local County Department of Social Services staff had reported to the facility with an allegation of abuse against Staff #5. -It was alleged that Staff #5 assaulted Client #1 on the previous day. -Results of internal investigation were as follows: -Client #1 stated that Staff #5 had hit and pushed him, causing him to fall and strike his face on his bed during an incident on the previous day. -Staff #5 stated that while preparing for shift time on the previous day, he had asked Client #2 and	V 517		

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V 517	Continued From page 6 Client #1 to go into their room while the staff changed over. -Both clients refused repeatedly. -Client #1 became both verbally and physically aggressive towards Staff #5, punching him in the face. -Staff #5 stated that he and Staff #6 attempted to perform a therapeutic hold on Client #1 as he continued to be physically aggressive. -They were unable to complete the hold, however as Client #1 pulled away and all three of them fell to the floor. -Staff #5 stated that at no time did he strike or push Client #1. -Staff #6 stated that she had entered the suite as Client #1 became physically aggressive towards Staff #5. -She immediately went to provide assistance as other staff in the suite were attempting to process with Client #2. -She and Staff #5 attempted a therapeutic hold, but before they could completely administer it, Client #1 pulled away and they all fell to the floor. -Other staff members were in the suite; however, they were all working with Client #2 and did not witness Client #1 or other staff members fall. -No other clients were in eye distance of the incident. Review on 6/18/20 of Client #1's discharge paperwork from regional emergency department revealed: -Report was dated 5/25/20. -Reason for visit: Assault Victim. -He was diagnosed with a fracture of left orbital floor. -Condition was caused by a hit to the eye. -Condition was diagnosed with an eye exam and an X-ray or Cat scan. -Symptoms of this condition included: A black	V 517		

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eye, pain around the eye, numbness on the cheek and upper gum, a headache and ear pain.
-Usually, treatment was not needed for this condition.
-In almost all cases, the broken bone heals on its own.

Interview on 6/16/20 with Client #1 revealed:
-He and Client #2 did not want to do "down time" prior to incident.
-Staff was talking to them, but they were not saying anything back to them.
-Client #2 was being restrained.
-He started to question staff on why they were restraining Client #2.
-Staff #5 responded to him with "Shut the F up!"
-He responded to Staff #5 that he was not his dad.
-Staff #5 told him to lay on his bed.
-He declined to go to his bed.
-Staff #5 started to test Client #1 by shoving and pushing him.
-He took a swing at Staff #5.
-Staff #5 slammed Client #1 down and started to punch him in the face.
-Staff #6 was in the room with them.
-Staff #6 asked Staff #5 to stop.
-Client #1 denied hitting his face on the bed frame when he was slammed down on his bed.
-He was taken to the nurse station to be checked.
-He was seen by nurse, given an ice pack and Ibuprofen.
-Client #1 then ate dinner and went to sleep afterwards.
-Client #1 saw a medical doctor a few days later.
-Client #1 was told that he had a small fracture by his eye.
-Client #1 had never been hit by a staff at the center before.
-Client #1 had never seen a staff hit anyone at the

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center before.
-Client #1 felt safe at the center.

Interview on 6/16/20 with Client #2 revealed:
-Client #2 had been restrained several times at the center before (about three times).
-Client #2 had never been hit by a staff at the center before.
-Client #2 had never been hurt/injured from a restraint before.
-Client #2 stated he feels safe at the facility.
-On night of incident with Client #1, he did not see Client #1 being hit by Staff #5.
-Door to go inside the room was closed.
-He heard someone in the room being slammed down and what sounded like punches landing.
-Client #1 had a bruised eye.
-Client #1 told him that Staff #5 had slammed him down and punched him in the face.

Interview on 6/16/20 with Client #3 revealed:
-He had been restrained before at the center.
-He had never seen any staff members hit any of the clients.
-Client #3 stated he feels safe at the facility.
-He had heard Staff #5 had hit Client #1 in the face.

Interview on 6/16/20 with Client #4 revealed:
-He had been restrained at the center before.
-He had never seen staff hit anyone at the center.
-Client #4 stated he feels safe at the facility.
-He had not heard of any clients being hit by a staff at the center.

Interviews on 6/11/20 and 6/19/20 with the Child Protective Service investigator assigned to Client #1 revealed:
-Investigation was still active.
-She had interviewed Client #1 and other Clients

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at the center.
-Client #1 had been consistent with his statements that said Staff #1 had hit him in the face.
-Client #1 had told her that he was slammed down to the bed and not the floor.
-She had taken Client #1 to the regional emergency department.
-Client #1 was diagnosed with a fracture by his eye.
-Client #1 was not taken to the doctor for his injuries by the facility.

Interview on 6/9/20 with Detective from Local Law Enforcement revealed:
-She was investigating a case of Client #1 being hit by Staff #5.
-She stated their investigation is still open.

Interview on 6/19/20 with Staff #5 revealed:
-He had been suspended from working at facility since the incident with Client #1 occurred.
-On night of incident, he had been responding to a crisis call at the suite.
-Client #2 was demanding to have his electronics which had been taken away because he had been disrespectful.
-He was being asked to go to "down-time" for him to regain his electronics.
-Client #2 declined to go to down-time.
-Client #2 then started to incite Client #1 to get involved in the argument.
-Client #2 was inciting Client #1 to hit Staff #5.
-At one point, Staff #5 was looking at Client #2 and when he turned around, Client #1 threw a punch at him and hit him in the face.
-Staff #5 then grabbed a hold of Client #1's arm and started to do a therapeutic hold.
-Staff #6 was in the room and she grabbed a hold of the other arm.

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V 517	Continued From page 10 -Client #1 was resisting and went down to the floor. -When Client #1 went to the floor, everyone that was holding him also went down to the floor. -Client #1 hit his face on the corner of the bed when he went down to the floor. -After going to the floor, Staff #2 noticed the redness and puffiness on Client #1's face. -Therapeutic Hold was called off immediately. -Client #1 was taken to see the nurse. -Client #1 received an ice pack and was given ibuprofen by the nurse. -After seeing nurse, they talked with Client #1 about the restraint. -They talked about why he had been restrained and what he should have done to avoid being restrained. -Client #1 never mentioned to Staff #5 or anyone that he had been hit in the face by him. -Staff #5 denied ever hitting Client #1. Interviews on 6/16/20 and 6/22/20 with Staff #6 revealed: -She was present when the incident with Client #1 and Staff #5 occurred. -There was a crisis call made (935). -Other staff were dealing with Client #2 as he was being restrained. -Client #1 was interfering with Client #2's restraint. -Client #2 was telling Client #1 to get involved. -Client #1 was in his room and started to turn off and on the lights in this room. -Client #1 started to push Staff #5. -Client #1 then hit Staff #5 in the face. -She went inside the room with them. -She and Staff #5 tried to restraint Client #1, but he was fighting them off. -She and Staff #5 tried to get Client #1's arms, but they lost their balance and fell on the floor.	V 517		

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V 517	Continued From page 11 -Client #1 hit his face against the metal frame of the bed as they fell down. -Prior to the fall, Staff #5 and she were trying to get in a position to hold Client #1's arms. -They were cuffing their hands under Client #1's arms and trying to get a hold of his hands. -Client #1 was fighting them off. -When Client #1 fell forward first, motion brought her and Staff #5 down. -She was on the left side of Client #1. Staff #5 was on right side. -After they had fallen on the floor and she saw Client #1's face red and puffy around the eye, she told Staff #1 to stop. -Client #1 calmed down and he was taken to the nurse station to be checked. -She reported that everything happened really fast. -She never saw Staff #5 hit Client #1 in the face. -Client #1 never told her that Staff #5 had hit him. -She was surprised to hear the next day the allegation from Client #1 that Staff #5 had hit him in the face. -She acknowledged that the restraint failed and that Client #1 was hurt consequently. Interview on 6/22/20 with Nurse #2 revealed: -She was not working the night of the incident with Client #1. -Nurse #1 worked part time (as needed). -She had heard about the incident. -Client was seen by Nurse #1 on the night that he hit his face. -She was normally in charge of the facility whenever the Executive Director was not present at the facility. -Policy was for whenever a client needed to go to the emergency department, it would first be recommended by the Nurse on duty. -Executive Director would receive	V 517		

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recommendation from the Nurse and he would coordinate for the client to go to the emergency department.
-Executive Director was in charge of coordinating staff coverage at the facility and transportation for clients that needed to go to the emergency department.
-She was aware that Client #1 needed to go to the emergency department after incident on May 21st.
-Recommendation had been given by Nurse #1 for Client #1 to go to the emergency department.
-Recommendation was given to Executive Director for Client #1 to attend the emergency department.
-She did not know why it took four days for agency to take Client #1 to seek medical attention.
-She was under the impression that Client #1 was taken to the emergency department by staff at the facility and not by the CPS worker.

Attempt made on 6/22/20 to contact Nurse #1 to no avail. Message left on voice mail. Did not return call.

Interview on 6/15/20 with the Executive Director revealed:
-He was not working at the facility when the incident occurred on 5/21/20.
-Department of Social Services (DSS) had gone to the facility and talked to the boys.
-DSS was still conducting their investigation and he was awaiting the results.
-Staff #5 had been suspended since incident occurred and he is awaiting result from DSS and State investigations.
-Facility used the CPI Nonviolent Crisis Intervention Training curriculum.
-Safety measures in place were ongoing policies

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON SPRINGS TREATMENT CENTER	778 HOFFMAN ROAD WEST END, NC 27376

(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 517	Continued From page 13	V 517		

on safety, review of CPI restraining techniques.
-Facility's policy on physical restraint was for a nurse, first responder or team leader to make the call for a physical restraint.
-Physical restraints were only done when the client was in jeopardy of hurting themselves or others.
-Physical restraints are administered only when the client had both feet on the floor. If they dropped to the floor, the restraint is called off.
-"Down Time" was defined as a period of transition between activities.
-Clients were supposed to go to their rooms and reflect during down time and get ready for the next activity.
-Physical restraints were not to be conducted if a client declined to do "down time."
-Consequences for not wanting to do down time were: no electronics or an extended quiet time.
-Programs at facility were geared to the client, but they were to also follow a structure.
-After a physical restraint, nurses assessed the client.
-Nurse #1 worked part time (as needed).
-A debriefing was conducted with the staff afterwards to talk about what staff could have done better in order to prevent the restraint.
-A debriefing was also conducted with the client afterwards to talk about what happened and what they could have done to prevent the restraint.
-He had spoken with Staff #5 and #6 as well as Clients #1 and #2 about the incident.
-He was told by Client #1 that Staff #5 had hit him.
-Staff #5 told him that Client #2 had a crisis call.
-Client #2 did not want to go and do "down time".
-Client #1 had been flicking the lights on/off.
-Staff #5 told Client #1 to stop.
-Client #1 swung at Staff #5.
-Client #1 and Client #2 were trying to jump on

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V 517	Continued From page 14 Staff #5. -He acknowledged that precipitating event was when Client #2 was going to be placed into a therapeutic hold for not wanting to do down time and becoming verbally aggressive. -After the incident, he was not aware that Client #1 needed to seek emergency medical treatment. -He felt that a bruised eye at first did not warrant going to the hospital emergency to be checked. -He acknowledged that Client #1 was hurt as a result of a failed therapeutic restraint. Interview on 6/19/20 with the Vice President of Administration revealed: -She had completed the initial investigation regarding allegation of abuse of Staff #5 against Client #1. -She found allegation to be unsubstantiated. -She could find no evidence that Staff #5 had hit Client #1. -Facility used the CPI Nonviolent Crisis Intervention Training curriculum. This deficiency is cross referenced into 10A NCAC 27G .1901 Psychiatric Residential Treatment for Children and Adolescents-Scope (V314) for a Type A-1 rule violation and must be corrected within 23 days.	V 517		