STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-125	A. BUILDING: _____ B. WING _____	07/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEWOOD FACILITY	2002 A & B SHACKLEFORD ROAD KINSTON, NC 28502

(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 A complaint survey was completed on July 23, 2020. The complaint was substantiated (intake #NC00167029). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .1900, Psychiatric Residential Treatment for Children and Adolescents.	V 000		
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 2 of 3 Staff (Staff #1 and #2) and 1 of 1 Former Staff (FS#4) audited failed to use a restrictive interventions in a manner that would not cause harm or abuse for 1 of 1 clients audited (client #2) and 1 of 1 former clients (FC#3) audited. The findings are: Finding #1: Review on 7/21/20 of Staff #1's record revealed:	V 517		

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V 517	Continued From page 1	V 517		

-Hire date was 6/10/19.
-Position was paraprofessional
-NCI+ (National Crisis Interventions Plus) Prevention, Restrictive, and Defensive (Prevention & Defensive) completed 6/2/20.

Review on 7/21/20 of Staff #2's record revealed:
-Hire date was 8/5/19.
-Position was paraprofessional
-NCI+ (National Crisis Interventions Plus) Prevention, Restrictive, and Defensive (Prevention & Defensive) completed 1/29/20.

Review on 7/16/20 of client #2's record revealed:
-15 year old male admitted 6/11/20.
-Diagnoses included oppositional defiant disorder (ODD); attention deficit hyperactive disorder (ADHD); Disruptive Mood Dysregulation Disorder (DMDD); other trauma and stressor related.
-Medical Progress note dated 7/6/20 documented:
-9:10 pm client #2 was physically aggressive toward staff and peers and damaging property.
-9:20 pm staff escorted client #2 from the bathroom to his bedroom.
-9:32 pm the nurse obtained a verbal order for Ativan 4 mg IM (intramuscularly) "now" for 1 dose.
-9:40 pm staff reported client #2 was trying to tie a blanket around his neck. Blanket and sheets were removed from his room. His aggressive behavior continued.
-9:52 pm the Ativan 4 mg was administered while the client was in a physical restraint.
-10:51 pm the nurse assessed the client. No injuries were noted. The client denied wanting to hurt himself.
-No documentation the client was put in a restrictive intervention between 9:40 pm and 9:52 pm.

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V 517	Continued From page 2 Review on 7/15/20 of the North Carolina Incident Response Improvement System (IRIS) reports for facility incidents on 7/6/20 revealed: -A level II incident report for a restrictive intervention of client #2 at 9:51 pm. Client #2 had been placed in a standing restraint for 1 minute and a sitting restraint for 4 minutes. -A level III incident report for Client #2's allegation that Staff #1 had come into his room on 7/6/20 and tried to take his items out of his room. Then Staff #2 came into his room. Client #2 alleged Staff #1 and #2 "slammed him into his bed," Staff #1 "choked him," and Staff #2 stated he was going to "F--k him up." Review on 7/15/20 of the Internal Investigation of client #2's allegation for incident on 7/6/20 revealed: -The Physical Assessment for the allegation dated 7/7/20 at 6:45 pm noted a 7.5 cm (centimeter) linear superficial abrasion over client #2's elbow. -Staff #2's written statement included in the internal investigation, dated 7/7/20 documented: -Staff #2 was called to the facility "after bedtime" because client #2 was having behaviors. -On arrival to the facility client #2 was in the day area, refusing to go to bed. -Client #2 became physically aggressive with staff and was allowed time to "process." -Client #2 then went to his room and slammed the door and continued to be "destructive." -Staff #1 entered the room to see what was happening with client #2. -Client #2 was on his bed with a do rag tied around his neck under the covers. -Staff #1 took the do rag from client #2.	V 517		

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V 517	Continued From page 3 -Client #2 became "extremely combative" and tried to fight with staff #1. Staff #1 was able to "contain" client #2. Staff #1 and client #2 fell to the bed and the client pushed Staff #1 to the floor. -Staff #2 "stepped in" and held the consumer. When he released the client, client #2 tried to "charge" staff #2. -The Nurse's written statement included in the internal investigation, dated 7/7/20 documented: -At 9:51 pm on 7/6/20 a "TW" (therapeutic walk) with 2 staff was initiated. Client #2 continued to be fight, kick, spit, and hit. -At 9:52 pm Ativan was administered while restrained. -Client #2 went from a standing "TW" from 9:51 pm to 9:52 pm to a sitting restraint at 9:52 pm. -There was no level II incident report for a restrictive intervention done prior to 9:51 pm by Staff #1 or Staff #2, during which time the client and staff fell onto the client's bed. Interview on 7/16/20 client #2 stated: -He got upset and the staff got upset with him. -He was told to go to bed. -A female staff called another staff over to the facility. -He went to his room and put his toboggan over his face and was listening to music. -Staff #1 entered his room and "snatched his toboggan" and "flung him on the bed." -His toboggan was laying across his face. -He had a scratch from staff holding him down. Unable to interview Staff #1 on 7/20/20, 7/22/20, or 7/23/20 as staff did not return calls from surveyor.	V 517		

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V 517	Continued From page 4 Interview on 7/20/20 Staff #2 stated: -He was involved in a recent restraint of client #2. -Client #2 was trying to not go to bed. -When client #2 did get into his room he slammed his door, and started punching walls. -Staff #1 opened client #2's door. -When Staff #2 went into client #2's room Staff #1 had client #2 in a "hold" and both client #2 and Staff #1 fell on the bed. Then client #2 pushed Staff #1 onto the floor. -When Staff #2 got to client #2's door he did not see the do rag around client #2's neck, but he saw his sheet around his head. -Staff #2 did not hear any threatening or inappropriate remarks or threats and denied making any inappropriate comments, threats, or use any curse words. Interview on 7/23/20 the Nurse stated: -She recalled the restrictive intervention with client #2 on 7/6/20; she was the only nurse on duty and did the assessment post restraint. -Prior to the restrictive intervention she witnessed client #2's defiant behavior (i.e. flipping lights on and off), and left the facility to go to another building to call the physician for a medication order in response to client #2's behaviors. -Client #2 had not been put into a restraint before she left to call the physician. -When she returned to the facility she was told by staff that the client tried to tie a blanket around his neck and they were in his room removing items. His behaviors had escalated. He was kicking the walls, throwing things off of the shelf, and hitting the shelf with his body. She made the call to put him in a RI and administered the Ativan ordered by the physician. Finding #2: Review on 7/23/20 of FS #4's record revealed:	V 517		

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-Hire date was 8/12/19.
-Termination date 6/7/20 (resigned).
-Position was paraprofessional
-NCI+ (National Crisis Interventions Plus) Prevention, Restrictive, and Defensive (Prevention & Defensive) completed 5/5/20.

Review on 7/16/20 of FC#3's record revealed:
-15 year old male admitted 1/9/20.
-Diagnoses included DMDD; Conduct Disorder; other trauma and stressor related disorder; and, Intellectual Developmental Disability, Mild.

Review on 7/15/20 of the North Carolina Incident Response Improvement System (IRIS) reports for facility incidents on 5/13/20 revealed:
-A level II incident report documented FC#3 had been placed in a sitting restraint for 4 minutes at 9:46 pm.
-A level III incident report documented FC#3 made an allegation on 5/14/20 that FS#4 had choked the client during a physical altercation on 5/13/20 while the client was on the ground and the staff said he was going to kill him.
-No level II incident report of a standing restraint and fall to the floor between 9 pm and 9:46 pm by FS#4.

Review on 7/15/20 of the Internal Investigation of FC#3's allegation for incident on 5/13/20 revealed:
-The Physical Assessment for the allegation dated 5/14/20 at 8:15 am abrasions over FC#3's left elbow and right hand.
-FS#4's written statement read as follows: "Staff ask consumer to get ready for bed because it was nine o'clock. Consumer refused to comply. Staff redirected over and over and consumer ignored. Consumer told staff he wasn't going to bed. Staff therapeutically escorted consumer out

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of day area. Consumer became very combative. Consumer attempted to swing on staff. Staff tried to put consumer in a therapeutic restraint. The other staff (Staff #3) walked out of the house leaving me (FS#4) with the consumers. I failed the first attempt of the therapeutic restraint. Consumer continued to be combative. I went to do another therapeutic restraint and I and consumer stumbled and hit the floor. Consumer began kicking me on the floor. Consumer tried to get up and fight staff. Staff held consumer down. Staff let consumer up and consumer charged at staff. Consumer grabbed broom, and chased staff (me) into the bathroom. Staff remained in the bathroom until consumer in his room and another staff tapped me out."
-Staff #3's written statement read as follows: "Consumer (FC#3) was redirected several times to go to his room after 9pm. After 20 mins (minutes) of redirecting we [FS#4] and I tried escorting [FC#3] to room. [FC#3] then started pulling away and ran towards door. I grabbed [FC#3] to get him to calm down, and he broke away and walked up on me like he wanted to fight. [FS#4] grabbed him (FC#3) from behind and held him. While he (FS#4) held him (FC#3) I (Staff #3) ran into the office to call the S.O.D (supervisor on duty)..."
-Internal Investigation Interview on 5/14/20 of FS#4 documented:
-FS#4 knew Staff #3 had left the area when he attempted to place FC#3 in a therapeutic restraint.
-FS#4 knew FC#3 was known to be extremely aggressive usually taking 3 or more strong staff to restrain him.
-FS#4 was "trying hard" to secure the restraint, but the consumer was extremely aggressive taking them to the floor on one occasion.

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V 517	Continued From page 7 -FC#3 was able to "break loose but was on his knees." -FS#4 was looking for a way to "disengage the restraint but keep the consumer from "aggressing him." -FS#4 admitted "he held the consumer by the back of his neck down but was not trying to hurt him but just create enough distance to get away." Interview on 7/23/20 Staff #3 stated: -He recalled the incident on 5/13/20 when FS#4 restrained FC#3. -He and FS#4 had told FC#3 to go to bed at least 20 times. After a while they tried to walk, escort, FC#3 to his room, but, FC#3 said he was not going. FS#4 tried to walk FC#3 and an altercation occurred, FC#3 started to fight. -They (Staff #3 and FS#4) tried to "wrap him" (FC#3). -Staff #3 went to the office to call the Supervisor, but no one answered the phone. -Staff #3 then left the office and opened the facility door to call for help and FC#3 ran out the door. -FC#3 was "wrapped" and medicated later that night and finally fell asleep.	V 517		