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	MHL078-325	A. BUILDING: _____ B. WING _____	07/14/2020

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RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

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V 000	INITIAL COMMENTS A complaint survey was completed on July 14, 2020. The complaint was unsubstantiated (intake # NC00166794). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1800 Intensive Residential Treatment for Children or Adolescents.	V 000		
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 responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112	DHSR-Mental Health AUG 13 2020 Lic. & Cert. Section	

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement strategies based on assessment for one of six audited clients (#9). The findings are: Review of client #9's record revealed: - 9 year old male. - Admission date of 04/21/2020. - Diagnoses of Disruptive Mood Dysregulation Disorder and Mild Intellectual Developmental Disorder. Review on 07/08/20 of client #9's Person-Centered Profile (PCP) completed on 06/09/20 revealed: - " Therapist and staff will:...Provide a structured environment for [client #9], Provide clear expectations and rules, Engage [client #9] with positive reinforcement, Process with [client #9] any behavioral incidents., Model/role play appropriate behavior, Encourage and praise [client #9] for utilizing his behavioral management skill." - Revealed no strategies related to restrictive interventions. - Revealed no strategies for room restrictions. Review on 07/07/20 of a typed statement for client #9 signed by the Qualified Professional (QP) revealed: - Date of interview: 07/03/20. - Time of interview: 11am. - "Have you (client #9) experience any physical, verbal, mental abuse? - No, but staff ([Staff #2])	V 112	**V112**: QP will ensure all strategies related to restrictive interventions and room restriction revealed in client #9 and all other client's Person Center Plan. QP will monitor monthly as needed during CFT Meetings	8/28/2020

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V 112	Continued From page 2 put his hands on him to restrained me because of behavior." Review on 07/06/20 of the North Carolina Incident Response Improvement System (IRIS) website revealed: - No level 2 incident reports for client #9 from May 2020 to present (07/14/20). Review on 07/09/20 of Renewing Grace Residential Home Progress Notes for client #9 revealed: - 05/15/20, 1st shift, client sent to his room for a second time to get himself together. - 05/16/20, 1st shift, client was in his room all shift. - 05/28/20, 2nd shift, client sent to room after redirection. - 05/29/20, 2nd shift, client was redirected to his room due to incident prior day. Interview on 07/08/20 client #9 stated: - He was 9 years old. - He got along well with clients and staff. - Staff puts his hands behind his back. Interview on 07/08/20 client #10 stated: - He was 13 years old. - He had resided at the facility for approximately 3 months. - Staff #2 and staff #9 restrain client #9 in his room at times. - Client #9 is restrained the most at the facility. Interview on 07/08/20 staff #2 stated: - He had been employed with facility since May 2020. - He had worked 2nd shift from 3-11pm. - He had completed all training required to work with clients.	V 112		

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V 112	Continued From page 3 - He had only stepped in between a client and staff for interventions. - He had not witnessed any staff be inappropriate. - He had not had to restrain any clients. Interview on 07/08/20 staff #12 stated: - He had worked at the facility for almost a year. - He had worked 2nd and 3rd shifts. - He had held client #9's arms and/or legs for an hour off and on, while he was on his bed to prevent him from hurting himself. - Client #9 had severe episodes once a week. - It could take 2 or 3 staff to intervene with client #9. - He had not used any restraints on any clients. Interview on 07/09/20 staff #6 stated: - He had worked at the facility since it opened. - He had worked 1st shift. - He had not done any restrictive interventions. - As a last result they use therapeutic holds when a client had self injurious behaviors. Interview on 07/09/20 staff #5 stated: - He had worked at the facility since it opened. - He had worked 1st shift, 7am - 3pm. - He had not seen any staff use restrictive interventions. - He had seen room restrictions lasting a day or two and clients are only allowed out to eat, use restroom and go outside. -They are not allowed to interact with other clients. Interview on 07/08/20 the Qualified Professional stated: - Staff held client #9 arms down when he is aggressive - She had not seen any inappropriate restrictive holds.	V 112		

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V 112	Continued From page 4 - Room restrictions depend on the clients' behaviors and can last a day. - No documented restrictive interventions were completed by staff. - She understood the PCP needed to include strategies implemented by staff. This deficiency is cross referenced into 10A NCAC 27G .1801 Scope for a Type B rule violation and must be corrected within 45 days.	V 112		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services).	V 132		

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V 132	Continued From page 5 Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to report allegations of abuse to the Health Care Personnel Registry (HCPR). The findings are: See Tag V367 for specifics. Review on 07/13/20 of the North Carolina Incident Response Improvement System (IRIS) website from May 2020 thru present revealed: - No allegations of abuse against facility staff were submitted to the HCPR as required. Interview on 07/13/20 the Qualified Professional stated: - She had completed internal investigations for allegations of abuse involving staff #2, #6, #9, and #10. - She had not submitted the 07/02/20 allegation to HCPR since she did not have a named client. - She understood any allegations of abuse	V 132	**V132**: QP will ensure all allegations of abuse against the facility staff be reported to Health Care Personnel Registry (HCPR). All results of findings will be reported to the HCPR within working days of the initial notification to the HCPR. QP will monitor weekly.	8/28/2020

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V 132	Continued From page 6 required a report to the HCPR. - She understood the results of all investigations must be reported to the HCPR within five working days of the initial notification to the HCPR. This deficiency is cross referenced into 10A NCAC 27G .1801 Scope for a Type B rule violation and must be corrected within 45 days.	V 132		
V 301	27G .1801 Intensive Res. Tx. Child/Adol - Scope 10A NCAC 27G .1801 SCOPE (a) An intensive residential treatment facility is one that is a 24-hour residential facility that provides a structured living environment within a system of care approach for children or adolescents whose needs require more intensive treatment and supervision than would be available in a residential treatment staff secure facility. (b) It shall not be the primary residence of an individual who is not a client of the facility. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, severe emotional and behavioral disorders or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for acute inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to an intensive integrated treatment setting; and (2) treatment in a locked setting. (e) Services shall be designed to: (1) assist in the development of symptom and behavior management skills; (2) include intensive, frequent and	V 301		

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V 301	Continued From page 7 pre-planned crisis management; (3) provide containment and safety from potentially harmful or destructive behaviors; (4) promote involvement in regular productive activity, such as school or work; and (5) support the child or adolescent in gaining the skills needed for reintegration into community living. (f) The intensive residential treatment 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 reviews and interviews, the facility failed to meet the scope of the license for an intensive residential treatment facility identified to provide intensive treatment and supervision in the residential setting affecting four of six audited clients (#3, #8, #9 and #10). The findings are: Cross Reference: 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (V112). Based on record reviews and interviews, the facility failed to develop and implement strategies based on assessment for one of six audited clients (#9). Cross Reference: G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (V132). Based on record review and interviews the facility failed to report an allegation of abuse to the Health Care Personnel Registry (HCPR).	V 301	**V301**: QP will ensure the facility meet the scope of the license for an intensive residential treatment facility by providing intensive treatment and supervision in the residential setting affecting clients (#3, #8). QP will monitor weekly. **10A NCAC 27G .0205**-QP will ensure client #9 and all client's PCP plans are developed and implemented with strategies. QP will monitor monthly as needed. **G.S. S131E-256**-QP will ensure all allegations of abuse are reported to the Health Care Personnel Registry (HCPR). QP will monitor weekly.	8/28/2020 8/28/2020

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V 301	Continued From page 8 Cross Reference: 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL (V318). Based on record reviews and interviews the facility failed to report an allegation of abuse to the Health Care Personnel Registry (HCPR) within 24 hours of learning about the allegation.	V 301	**10A NCAC 130.0102**-QP will ensure all allegation of abuse to the Health Care Personnel Registry (HCPR) within 24 hours of learning about the allegation. QP will monitor weekly.	8/28/2020
	Cross Reference: 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (V367). Based on record reviews and interview, the facility failed to report a critical incident to the Local Management Entity (LME) as required.		**10A NCAC 27G.0604**-QP will ensure all critical incident reported to the Local Management Entity (LME) as required. QP will monitor weekly.	8/28/2020
	Cross Reference: 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (V500). Based on record review and interviews the facility failed to report an allegation of abuse.		**10A NCAC 27E.0101**-QP will ensure to report any allegation of abuse	8/28/2020
	Cross Reference: 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (521). Based on record reviews and interviews, the facility failed to ensure the necessary documentation was in the client record when a restrictive intervention was utilized affecting two of six audited clients (#9 and #10).		**10A NCAC 27D.0104**-QP will ensure all necessary documentation was in clients (#9 and #10) and all other client's record when restrictive intervention is utilized. QP will monitor weekly.	8/28/2020
	Cross Reference: 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (V536). Based on record review and interview, the facility failed to ensure one of nine audited paraprofessional staff (#1) had training in the use of alternatives to restrictive interventions prior to providing services.		**10A NCAC 27E.0107**- QP will ensure all facility staff (#1) and all new staff will be trained and all has been retrained in the use of alternatives to restrictive such as CPI Holding Techniques. QP will monitor as needed.	8/28/2020

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V 301	Continued From page 9 Cross Reference: 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (V537). Based on record reviews and interviews, the facility failed to ensure four of nine audited paraprofessional staff (#2, #9, #12 and #16) demonstrated competence in the proper use of seclusion, physical restraint and isolation and failed to train one of nine audited paraprofessional staff (#1) in the proper use of seclusion, physical restraint and isolation. Review on 07/13/20 of a Plan of Protection signed by the Qualified Professional (QP) on 07/13/20 revealed: - "What immediate action will the facility take to ensure the safety of the consumers in your care? The immediate action that will be taken to ensure safety of the consumer while in Renewing Grace Residential Group Home care is to make sure all staff are retrain and train on CPI (Crisis Prevention Institute) Techniques, How to deescalate behaviors properly, when and how to report incident and accidents report, how to report abuse, neglect and exploitation. Train on what is Abuse and Neglect, and What is considered abuse and neglect. Staff will also be trained on development of symptoms and behavior management skills. QP will go through all PCP (Person Centered Plan) Plan and make sure each client has pre-planned crisis management. Once, any allegation is reported to QP, QP will submit the allegation in the NC IRIS System. All staff that does not have CPI Training will be taken off shift until training is offered. - Describe your plans to make sure the above happens. The plan to make sure the above happens by having all staff be trained and retrained by scheduling dates for training. CPI	V 301	**10A NCAC 27E. 0108**- QP will ensure all facility staff (#2, #9, #12, and #16) and all other staff will be train on how to demonstrate competence in the proper use of seclusion, holding skills and isolation and train and retrain on client's rights. and train facility staff (#1) and all other staff in the proper use of seclusion, holding skills and isolation. QP will monitor weekly.	8/28/2020

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V 301	Continued From page 10 Training will be July 16, 2020 and July 21, 2020; How to deescalate behaviors properly, When and How to Report Incident and Accidents, How to Report Abuse, Neglect and Exploitation; What is Abuse and Neglect, and What is Considered Abuse and Neglect on July 17, 2020 and July 20, 2020. If staff is under any type of investigation, staff will be pulled off shift until investigation is completed. All trainings will be on-going. If staff does not report to training, staff will be taken on shift until next training is offered. QP will ask each clients the following questions on a weekly basis: 1. Do you have any problems with the staff? 2. Have you experienced any physical, verbal, mental abuse? 3. Do you like it here? 4. Have you being mistreated by anyone? 5. Have you been bullied by anyone? 6. What can we do better to help with your treatment?" Clients at the facility had diagnoses which included Disruptive Mood Dysregulation Disorder, Mild Intellectual Developmental Disorder, Attention Deficit Hyperactivity Disorder and Oppositional Defiant Disorder. The clients' ages range from 9 to 16 years old. Client #9's Person-Centered Profile revealed no strategies for room restrictions or restrictive interventions. The facility used room restrictions based on the clients' behaviors however, there was no consistency during interviews with staff on how long restrictions may last. Client #10 reported staff #2 and staff #9 would restrain client #9 in his room for an hour or two. Staff #12 stated it was against policy to use any restrictive holds on clients however, he held client #9's arms and legs while on his bed to prevent self-injurious behaviors. Interviews with multiple staff, stated once a client is down, you can no longer use a hold. There is no documentation of restrictive interventions as repported by staff and clients.	V 301		

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V 301	Continued From page 11 Staff #1, who had worked at the facility for approximately 4 weeks without any training in the use of restrictive interventions, stated she had witnessed staff #2 put client #3 in a headlock and slam client on the bed. Staff #2 was interviewed about the allegation, but the allegation was not documented in IRIS. The facility recommended staff #2 be retrained in CPI. Staff #1 also reported she had seen staff #16 put clients' arms behind their backs. There were multiple interviews from clients and staff of observed physical restrictive interventions employed by staff without any accompanying documentation. The QP reported staff had not communicated when physical restraints had been used. This failure of staff to report these occurrences resulted in a lack of documentation, a collapse in the ability to determine the cause of incidences, the failure to implement corrective actions and identify and assess ongoing needs for the clients served. The facility had not notified the required agencies of serious occurrences involving abuse allegations against staff. These ongoing systemic failures and the lack of strategies to address restrictive interventions, ensure training, use of room restrictions, the absence of required documentation and reporting requirements and investigation of incidents was detrimental to the health, safety and welfare of the clients. This deficiency constitutes a Type B rule violation. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance.	V 301		
V 318	13O .0102 HCPR - 24 Hour Reporting 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL	V 318		

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V 318	Continued From page 12 The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g). This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to report allegations of abuse to the Health Care Personnel Registry (HCPR) within 24 hours of learning about the allegation. The findings are: See Tag V367 for specifics. Review on 07/13/20 of the North Carolina Incident Response Improvement System (IRIS) website from May 2020 thru present revealed: - No documented evidence the allegations of abuse against facility staff were submitted to the HCPR within 24 hours as required. Interview on 07/13/20 the Qualified Professional stated: - She had completed internal investigations for allegations of abuse. - She had not submitted the 07/02/20 allegation to HCPR since she did not have a named client. - She understood any allegations of abuse required a report to the HCPR within 24 hours.	V 318	**V318** QP will ensure all allegations of abuse are reported to the Health Care Personnel Registry (HCPR) within 24 hours of learning about the allegation. QP will monitor weekly.	8/28/2020

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V 318	Continued From page 13 This deficiency is cross referenced into 10A NCAC 27G .1801 Scope for a Type B rule violation and must be corrected within 45 days.	V 318		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:	V 367		

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V 367	Continued From page 14 (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client;	V 367		

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V 367	Continued From page 15 (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report critical incidents to the Local Management Entity (LME) as required. The findings are: Review on 07/13/20 of the North Carolina Incident Response Improvement System (IRIS) website from May 19, 2020 thru July 13, 2020 revealed no documented level II incident reports for allegations of abuse as required. Finding #1: Review of client #3's record revealed: - 15 year old male. - Admission date of 01/30/2020. - Diagnoses of Conduct Disorder, ADHD (Attention Deficit Hyperactivity Disorder), Oppositional Defiant Disorder. Review on 07/07/20 of a typed statement for staff #1 and signed by the Qualified Professional (QP) revealed: - Date: 07/03/20.	V 367	V367 QP will ensure all critical incidents be reported to the Local Management Entity (LME) as required. QP will monitor weekly.	8/28/2020

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V 367	Continued From page 16 - Time: 2:00pm. - "Have you seen or heard any of the staff handling behaviors the wrong way? - Yes, [Client #2] was in a behavior [Staff #2] had put him in a headlock and slam him on the bed." Interview on 07/10/20 staff #1 stated: - She had worked at the facility for approximately 4 weeks. - She worked second shift: 3pm to 11pm. - She had not been trained in Crisis Prevention Institute (CPI). - She had seen staff at times put client's arms behind their backs. She did not know what proper restraints looked like because she had not been trained. - She told the QP she saw staff #2 put client #3 in a headlock and slam him on the bed during her 4 week employment (06/10/20 to 07/14/20). Interview on 07/09/20 client #3 stated he not been placed in any physical holds at the facility. He had not been put down on his bed. It was difficult to interview client via phone as he would only respond to direct questions with yes or no. Finding #2: Review on 07/07/20 of a handwritten note signed by the QP and dated 07/02/20 revealed: - "On July 2, 2020 [Local County Department of Social Services (DSS)] came to the facility to conduct an investigation. DSS stated she has to with consumers and staff first before giving QP any details about the investigation. DSS talked to all 11 clients and all staff except for 1 staff including QP and Home Manager. DSS worker stated the facility is under investigation due to a complaint that was received about client's being physically abused by staff, QP was instructed by Residential Director to pull 5 staff off shift and call	V 367		

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V 367	Continued From page 17 an emergency house meeting for internal investigation. For the 5 staff that was pulled off shift to come in on Monday July 6, 2020 at designated time to ask them questions at the office. The internal investigation will go-on team July 2, 2020 to July 6, 2020." Interview on 07/13/20 the QP stated: - She had completed internal investigations for staff #1's allegation of abuse involving staff #2 and the DSS allegation of abuse. - DSS did not give her a specific client to complete the IRIS report. - She had not completed an IRIS report for staff #1's allegation against staff #2. - She was aware that any allegation of abuse should be documented in IRIS for level II incident reports. This deficiency is cross referenced into 10A NCAC 27G .1801 Scope for a Type B rule violation and must be corrected within 45 days.	V 367		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical	V 500		

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V 500	Continued From page 18 practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be	V 500		

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V 500	Continued From page 19 responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to report an allegation of abuse to the local Department of Social Services (DSS). The findings are: See Tag V367 for specifics. Review on 07/13/20 of the North Carolina Incident Response Improvement System (IRIS) website from May 2020 thru present revealed: - No documented evidence the allegation of abuse against facility staff #2 was submitted to the local DSS as required. Interview on 07/13/20 the Qualified Professional stated: - She had completed an internal investigation for the allegation of abuse against staff #2. - She had not submitted the 07/03/20 allegation to DSS as required. - She understood any allegations of abuse required a report to the local DSS. This deficiency is cross referenced into 10A NCAC 27G. .1801 Scope for a Type B rule violation and must be corrected within 45 days.	V 500	**V500**: QP will ensure all allegation of abuse, neglect, or exploitation of clients will be reported to the local Department of Social Services (DSS). QP will monitor weekly.	8/28/2020
V 521	27E .0104(e9) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION,	V 521		

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V 521	Continued From page 20 PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (9) Whenever a restrictive intervention is utilized, documentation shall be made in the client record to include, at a minimum: (A) notation of the client's physical and psychological well-being; (B) notation of the frequency, intensity and duration of the behavior which led to the intervention, and any precipitating circumstance contributing to the onset of the behavior; (C) the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used; (D) a description of the intervention and the date, time and duration of its use; (E) a description of accompanying positive methods of intervention; (F) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions; (G) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and (H) signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention.	V 521		

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V 521	Continued From page 21 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the necessary documentation was in the client record when a restrictive intervention was utilized affecting two of six audited clients (#9 and #10). The findings are: Review on 07/13/20 of the North Carolina Incident Response Improvement System (IRIS) website from May 19, 2020 thru July 14, 2020 revealed no documentation of restrictive interventions. Review on 07/07/20 of facility records from May 2020 thru July 6, 2020 revealed no documented restrictive interventions at the facility. Review on 07/07/20 of client #9's record revealed: - 9 year old male. - Admission date of 04/21/2020. - Diagnoses of Disruptive Mood Dysregulation Disorder and Mild Intellectual Developmental Disorder. Review on 07/07/20 of client #10's record revealed: - 13 year old male. - Admission date of 04/02/20. - Diagnoses of Attention Deficit Hyperactivity Disorder-Combined Type (Moderate) and Oppositional Defiant Disorder. Review on 07/07/20 of a typed statement for client #9 signed by the Qualified Professional (QP) revealed: - Date of interview: 07/03/20. - Time of interview: 11am. - "Have you (client #9) experience any physical,	V 521	**V521**: QP will ensure all necessary documentation be placed in the client's record when a restrictive intervention has been utilized affecting clients (#9 and #10) and all other clients. QP will monitor weekly.	8/28/2020

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V 521	Continued From page 22 verbal, mental abuse? - No, but staff ([Staff #2]) put his hands on him to restrained me because of behavior." Review on 07/07/20 of a typed statement for client #10 signed by the QP revealed: - Date of interview: 07/03/20. - Time of interview: 10am. - "Do you (client #10) have any complaints? - He (client #10) feels as if [Staff #9] and [Staff #2] is putting them in physical restraints for no reason especially [Client #9]." Interview on 07/08/20 client #9 stated: - He was 9 years old. - He was unsure of his length of stay at the facility. - He got along with all the staff. No mistreatment by staff. - Staff puts his hands behind his back. Interview on 07/08/20 client #10 stated: - He was 13 years old. - He had resided at the facility for approximately 3 months. - Staff #2 and staff #9 restrain client #9 in his room at times. -Client #9 is restrained the most at the facility. - He had been restrained on his bed by staff #2 one time on his bed. -He had a nose bleed but he was not sure if it was an accident. Interview on 07/10/20 staff #1 stated: - She had worked at the facility for approximately 4 weeks. - She worked second shift: 3pm to 11pm. - She had not been trained in Crisis Prevention Institute (CPI). - She had seen staff at times put client's arms	V 521		

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V 521	Continued From page 23 behind their backs. She did not know what proper restraints looked like because she had not been trained. Interview on 07/08/20 staff #2 stated: - He had not seen any clients be mistreated at the facility. - He had CPI training. - He did not put hands on the clients. He would stand in between clients during altercations. - Staff would "guide" clients to their rooms at times. Interview on 07/08/20 staff #12 stated: - He had worked at the facility since it was opened. - He had all the required training. - He had not seen any mistreatment by staff towards the clients. - The facility did not use physical restraints. He did have to occasionally hold client #9 on the bed. 2 staff would be required to hold client #9 during severe behaviors to prevent injury. One staff would hold client #9's arms and the other staff would hold client #9's legs. - "[Client #9] had 3 or 4 real bad episodes." - He was not aware of any reports being completed for the behaviors of client #9. Interview on 07/13/20 the QP stated: - The facility staff did document clients had been placed in therapeutic holds. - She understood any time a staff placed a client in a physical hold the correct documentation should be completed. The information was to be used to track behaviors and interventions. - She indicated she would follow up on issues related to restraint documentation with staff. This deficiency is cross referenced into 10A	V 521		

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V 521	Continued From page 24 NCAC 27G. .1801 Scope for a Type B rule violation and must be corrected within 45 days.	V 521		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (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 wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the	V 536		

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V 536	Continued From page 25 following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for 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 Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

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V 536	Continued From page 26 aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) 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. (4) 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 (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) 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	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 536	Continued From page 27 outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) 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. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure one of nine audited paraprofessional staff (#1) had training in the use of alternatives to restrictive interventions prior to providing services. The findings are: Review on 07/14/20 of staff #1's personnel information revealed: - Date of hire: 06/10/20. - Job: Paraprofessional staff. - No training in Crisis Prevention Institute (CPI) prior to providing services at the facility. Interview on 07/10/20 staff #1 stated: - She had worked at the facility for approximately 4 weeks.	V 536	**V536**. QP will ensure all facility staff (#1) and all new staff will be trained and all has been retrained in the use of alternatives to restrictive such as CPI Holding Techniques. QP will monitor as needed.	8/28/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 536	Continued From page 28 - She worked second shift: 3pm to 11pm. - She had not been trained in CPI. - She had seen staff at times put clients' arms behind their backs. -She did not know what proper restraints looked like because she had not been trained. Interview on 07/13/20 the Qualified Professional stated: - Staff #1 had not been trained in CPI before providing services at the facility. - Staff #1 was scheduled to take CPI training. - She understood training in the use of alternatives to restrictive interventions prior to providing services was required for each staff. This deficiency is cross referenced into 10A NCAC 27G .1801 Scope for a Type B rule violation and must be corrected within 45 days.	V 536		
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	V 537		

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V 537	Continued From page 29 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 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	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 537	Continued From page 30 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 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	V 537		

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V 537	Continued From page 31 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. (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	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 537	Continued From page 32 competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure four of nine audited paraprofessional staff (#2, #9, #12 and #16) demonstrated competence in the proper use of seclusion, physical restraint and isolation and failed to train one of nine audited paraprofessional staff (#1) in the proper use of seclusion, physical restraint and isolation. The findings are: Review on 07/13/20 of facility records from May 19, 2020 thru July 13, 2020 revealed no documented episodes of restrictive interventions. Finding #1: Review on 07/14/20 of staff #1's personnel information revealed: - Date of hire: 06/10/20. - Job: Paraprofessional staff. - No training in Crisis Prevention Institute (CPI) prior to providing services at the facility. Interview on 07/10/20 staff #1 stated: - She had worked at the facility for approximately 4 weeks. - She worked second shift: 3pm to 11pm. - She had not been trained in CPI. Finding #2: Review on 07/07/20 of client #3's record	V 537	**V537**: QP will ensure all facility staff (#2, #9, #12, and #16) and all other staff will be train on how to demonstrate competence in the proper use of seclusion, holding skills and isolation and train and retrain on client's rights. and train facility staff (#1) and all other staff in the proper use of seclusion, holding skills and isolation. QP will monitor weekly.	8/28/2020

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V 537	Continued From page 33 revealed: - 15 year old male. - Admission date of 01/30/2020. - Diagnoses of Conduct Disorder, Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD). Review on 07/14/20 of staff #2's personnel information revealed: - Date of hire: 05/13/20. - Job: Paraprofessional staff. - Completed a Nonviolent Crisis and Invention: Refresher - Blended training class (CPI) on 05/14/20. - Completed protection from harm, abuse, neglect, and exploitation training on 06/14/20. - Scheduled to complete CPI re-training on 7/16/20. Review on 07/07/20 of a typed statement for staff #1 and signed by the Qualified Professional (QP) revealed: - Date: 07/03/20. - Time: 2:00pm. - "Have you seen or heard any of the staff handling behaviors the wrong way? - Yes, [Client #3] was in a behavior [Staff #2] had put him in a headlock and slam him on the bed." Interview on 07/09/20 client #3 stated: - He had not been placed in any physical holds at the facility. - He had not been put down on his bed. Interview on 07/08/20 staff #2 stated: - He had not seen any clients be mistreated at the facility. - He had CPI training. - He did not put hands on the clients. He would stand in between clients during altercations.	V 537		

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V 537	Continued From page 34 - Staff would "guide" clients to their rooms at times. Interview on 07/10/20 staff #1 stated: - She had seen client #3 go into a behavior because a game was taken away from him. - She saw staff #2 push client #3 to his room. Staff #2 put client #3 in a headlock and slammed him on the bed. - She did not see any injury with client #3. - She was not sure what restrictive interventions should look like since she had not been trained. Finding #3: Review on 07/07/20 of client #9's record revealed: - 9 year old male. - Admission date of 04/21/2020. - Diagnoses of Disruptive Mood Dysregulation Disorder and Mild Intellectual Developmental Disorder. Review on 07/07/20 of client #10's record revealed: - 13 year old male. - Admission date of 04/02/20. - Diagnoses of Attention Deficit Hyperactivity Disorder-Combined Type (Moderate) and ODD. Review on 07/14/20 of staff #2's personnel information revealed: - Date of hire: 05/13/20. - Job: Paraprofessional staff. - Completed a Nonviolent Crisis and Invention: Refresher - Blended training class (CPI) on 05/14/20. - Completed protection from harm, abuse, neglect, and exploitation training on 06/14/20. - Scheduled to complete CPI re-training on 7/16/20.	V 537		

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V 537	Continued From page 35 Review on 07/14/20 of staff #9's personnel information revealed: - Date of hire: 10/31/2019. - Job: Paraprofessional staff. - Completed protection from harm, abuse, neglect, and exploitation training on 04/15/20. - Completed Nonviolent Crisis Intervention: Comprehensive training class (CPI) on 11/15/19. Review on 07/07/20 of a typed statement for client #9 signed by the QP revealed: - Date of interview: 07/03/20. - Time of interview: 11am. - "Have you (client #9) experience any physical, verbal, mental abuse? No, but staff [Staff #2] put his hands on him to restrained me because of behavior." Review on 07/07/20 of a typed statement for client #10 signed by the QP revealed: - Date of interview: 07/03/20. - Time of interview: 10am. - "Do you (client #10) have any complaints? - He (client #10) feels as if [Staff #9] and [Staff #2] is putting them (clients) in physical restraints for no reason especially [Client #9]." Interview on 07/08/20 client #9 stated: - He was 9 years old. - He got along well with clients and staff. - Staff puts his hands behind his back. Interview on 07/08/20 client #10 stated: - He was 13 years old. - He had resided at the facility for approximately 3 months. - Staff #2 and staff #9 restrain client #9 in his room at times. - Client #9 is restrained the most at the facility.	V 537		

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V 537	Continued From page 36 Interview on 07/08/20 staff #9 stated: - He had worked at the facility since it opened. - He has received all trainings to work with clients. - He had not seen any staff be inappropriate towards clients. - He had not been inappropriate with clients. - He had not had to use any physical restraints. Finding #4: Review on 07/14/20 of staff #12's personnel information revealed: - Date of hire: 07/24/2019. - Job: Paraprofessional staff. - Completed protection from harm, abuse, neglect, and exploitation training on 04/15/20. - Completed Nonviolent Crisis Intervention: Comprehensive training class on 07/29/19. Interview on 07/08/20 staff #12 stated: - He had worked at the facility since it was opened. - He had all the required training. - He had not seen any mistreatment by staff towards the clients. - The facility did not use physical restraints. - He did have to occasionally hold client #9 arms and legs while on the bed during severe behaviors to prevent self injury. - Client #9 behaviors would require at least 2 staff - "[Client #9] had 3 or 4 real bad episodes." - He was not aware of any reports being completed for the behaviors of client #9. Finding #5: Review on 07/14/20 of staff #16's personnel information revealed: - Date of hire: 10/14/2019. - Job: Paraprofessional staff.	V 537		

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V 537	Continued From page 37 - Completed protection from harm, abuse, neglect, and exploitation training on 04/15/20. - Completed Nonviolent Crisis Intervention: Comprehensive training class on 11/7/19. Interview on 07/10/20 staff #1 stated: - She had seen staff #16 at times put clients' arms behind their backs. She did not know what proper restraints looked like because she had not been trained. Interview on 07/08/20 staff #16 stated: - She had worked at the facility since it opened. - She had worked 2nd shift. - She had received all training to work with clients. - She had done restrictive holds by placing clients arms at their side. - She had not used any holds from May 2020 to 07/08/20 . - She had not seen any other staff use holds. Finding #6: Review on 07/13/20 of client #8's record revealed: - 16 year old male. - Admission date of 02/24/20. - Diagnoses of ADHD, Unspecified Trauma and Stress related Disorder and Autism Spectrum Disorder. Review on 07/13/20 of the North Carolina Incident Response Improvement System website revealed the following incident for client #8: - Date of incident: 05/23/20. - Time of incident: 12:23pm - "Describe the cause of this incident, (the details of what led to this incident). [Client #8] had a piece of wire in his hand. Staff (former staff #23) asked [Client #8] to give him	V 537		

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V 537	Continued From page 38 the wire. [Client #8] refused stated that he needed it. Staff again redirected [Client #8] to give staff the wire and explain that the wire was dangerous and [Client #8] could hurt himself. [Client #8] became upset by using profanity and stated that he was not going to give staff the f*****g wire. Staff then asked client [Client #8] to calm down and to put the wire on the table. [Client #8] suddenly rush staff attempting to bite. Staff attempt to step back and reaching for [Client #8] hand which at this point was kicking, hitting the staff. Staff lowered client hand to the side. [Client #8] dropped to the ground and continue to kick and hit the staff. Once he calmed down, staff 1 (FS #23) and staff 2 (#7) escorted him in the facility to the Medication Room. While escorting him in the facility, staff 2 (#7) notice [Client #8] lip started to bleed and abrasion on his left elbow. The abrasion was cleaned with warm soapy water and Neosporin was applied. Mouth rinse his mouth out with warm water. The RN (Registered Nurse) was called to come look at [Client #8] lip and his abrasion on left elbow. She notice that the cut on his top lip was a little deep and need to go to emergency room for evaluation. He was taken to the [Local] Medical Center. The Doctor put 1 stitch to his lip and prescribed antibiotics Amoxicillin 125mg (milligrams) Take 1 tablet by mouth 2 times a day for 5 days to prevent any infection while the lip is healing. Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. QP encourage Staff to continue to monitor clients and followed CPI Techniques. Staff must have walkie talkie with them when going outside. If need assistance, use the walkie talkie to call for assistance."	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(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 537	Continued From page 39 Interview on 07/08/20 client #8 stated: - He had resided at the facility for 5 months. - He had not been mistreated by staff. - He had not been injured by any staff member. - He did not recall the specifics of his injured lip. Interview on 07/09/20 staff #7 stated: - She had training in CPI. - She had not seen any clients mistreated. - No clients had made any allegations of abuse. - She had checked client #8's lip when he came into the facility. - Client #8 stated he bit his lip which caused the laceration. Interview on 07/13/20 the QP stated: - Staff #1 had not been trained in CPI before providing services at the facility. - Staff #1 was scheduled to take CPI training. - She understood training in the use of alternatives to restrictive interventions prior to providing services was required for each staff. - She would ensure staff received additional training in restrictive interventions. - She was not aware staff were restraining clients. staff #1 - She had seen staff #16 at times put clients' arms behind their backs. She did not know what proper restraints looked like because she had not been trained. This deficiency is cross referenced into 10A NCAC 27G .1801 Scope for a Type B rule violation and must be corrected within 45 days.	V 537		