STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	08/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

(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 08/14/2020. A complaint was substantiated (Intake #NC00167870) and a complaint was unsubstantiated (Intake #NC00167280). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and	V 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	08/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

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V 105	Continued From page 1 (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

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	MHL054-126	A. BUILDING: _____ B. WING _____	08/14/2020

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V 105	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement written standards that assured operational and programmatic performance meeting applicable standards of practice to report serious occurrences to the State designated Protection and Advocacy system. The findings are: Review on 8/11/2020 of the LME-MCO (Local Management Entity-Managed Care Organization) communication Bulletin J287, "Clarifying the Reporting Standards for Psychiatric Residential Treatment Facilities [PRTF]" dated 5/11/18 revealed: -"... Serious Occurrences are any event that result in Restraint or Seclusion, Resident's Death, Any Serious Injury to a Resident, and a Resident's Suicide Attempt. NC [North Carolina] 483.374 specifies that facilities must report each Serious Occurrence to ... unless prohibited by State Law, the State-designated Protection and Advocacy system (Disability Rights North Carolina - DRNC)." -"DRNC reports are to be faxed to (919) 856-2244." Review on 8/12/2020 of the facility's policy, "Consumer Death or Serious Occurrence / Sentinel Event," dated 6/1/16 revealed: -The policy statement read, "It is the policy of NOVA to define a Serious Occurrence / Sentinel Even as the death of a Consumer or any significant impairment of the physical condition of a Consumer as determined by NOVA's Primary Care Medical Director or other qualified Medical Personnel ..." -"Each Consumer Death or Serious Occurrence /	V 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	08/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

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V 105	Continued From page 3 Sentinel Event will be reported to Disability Rights of North Carolina (DRNC) within 24 hours of the event by fax, email and/or phone." Review on 08/11/2020 of a letter from DRNC to NOVA dated 02/18/2020 revealed: "-RE: All Psychiatric Residential Treatment Facilities are required to report each serious occurrence to DRNC under the CMS Conditions of Participation... -Since 2018, DRNC has only received three serious occurrence reports from NOVA, Inc., which currently operates three PRTF's; [Facility], [Facility] and [Facility]. Therefore, it is highly likely that NOVA, Inc. is not in compliance with the federal requirement to submit serious occurrence reports to DRNC for each serious occurrence that occurs. This matter needs immediate attention..." Interview on 8/11/2020 the Program Director stated: - There had been a lot of "back and forth" between her and DRNC regarding reporting serious occurrences. - She had sent serious occurrence reports to DRNC according to federal rule criteria. - The last serious occurrence report had been sent on 4/11/2020, even though it did not meet criteria for a serious occurrence. The last serious occurrence that met criteria was on 3/14/2020 and was reported to DRNC. - The facility did not report restrictive interventions as a serious occurrence unless it resulted in an injury.	V 105		
V 517	27E .0104(c-d) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION	V 517		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	08/14/2020

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V 517	Continued From page 4 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) audited failed to use a restrictive intervention in a manner that would not cause harm or abuse for 1 of 1 clients audited (client #1). The findings are: Review on 08/12/2020 of client #1's record revealed: -15 year old female. -Admission date of 06/02/2020. -Diagnoses of Conduct Disorder, Unspecified, Severe, Major Depressive Disorder, Recurrent, severe without Psychotic features, Cannabis Abuse, Uncomplicated, Mild. Review on 08/05/2020 of Staff #1's record revealed: -Hire date of 09/30/19. -Paraprofessional. -The last documented National Crisis Intervention Plus (NCI+) training completed was on 04/01/2020. Review on 08/05/2020 of Staff #2's record	V 517		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	08/14/2020

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OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

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V 517	Continued From page 5	V 517		

revealed:
-Hire date of 03/16/2020.
-Paraprofessional.
-The last documented NCI+ training completed was on 03/18/2020.

Review on 08/14/2020 of the North Carolina Incident Response Improvement System report dated 07/13/2020 revealed:
"-Consumer (client #1) reported she had an unpleasant phone call with her guardian; therefore, she went to her room to calm herself after ending the phone call. Consumer stated staff did come to her room to check on her, but she did not want to talk at the time. Consumer stated, she then came out of her room to enter the kitchen to drink her milk; as staff asked her to put up the ice box. Consumer stated as she was in the kitchen, she heard her peers talking about her which angered her. Consumer stated she began using profanity and walked to her room and closed her door to separate herself from others. Consumer stated staff then came behind her yelling stating she was being disrespectful towards staff. Consumer stated she was confused as to why made the comment about being disrespectful towards staff due to not saying anything to staff. Consumer then reported she exited her room angry to go to the opposite side of the unit and began punching the wall. Consumer stated staff did not attempt to calm her or redirect her behavior to leave the area. Consumer stated instead staff attempted to place in a therapeutic hold, but was unsuccessful. Consumer reports when staff [Staff #1 and staff #2] was able to get her down to the floor staff [Staff #1] placed her knee on her face and neck. Consumer stated she asked staff [Staff #1] to get off her face and neck because she could not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	08/14/2020

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OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

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V 517	Continued From page 6	V 517		

breathe. Consumer stated she felt as though she was going to faint. Consumer stated staff [Staff #1] did not get off her face and neck due to consumer having staff [Staff #1's] hair in her hand. Consumer stated as she released staff [Staff #1's] hair, staff [Staff #1] remained on her face and neck."

Review on 08/05/2020 of the facility's internal investigation dated 07/20/2020 revealed:
"-Date of Allegation: 7/13/2020
-Nature of Allegation: Consumer, [Client #1] reported staff [Staff #1] and staff, [Staff #2] attempted to place consumer, [Client #1] in a therapeutic hold, but was unsuccessful. Consumer, [Client #1] reported when staff ([Staff #1 and Staff #2]) was able to get her down to the floor staff, [Staff #1] placed her knee on her face and neck. Consumer, [Client #1] stated she asked staff, [Staff #1] to get off her face and neck because she could not breathe. Consumer stated she felt as though she was going to faint. Consumer, [Client #1] stated staff, [Staff #1] did not get off her face and neck due to consumer, [Client #1] having staff, [Staff #1's] hair in hand. Consumer, [Client #1] stated as she released staff, [Staff #1's] hair, staff [Staff #1] remained on her face and neck.
-Interview Section:
[Client #1], Consumer: 7/14/2020: Consumer reported that on 7/13/2020 at 8:30pm she exited her room angry to go to the opposite side of the unit and began punching the wall. [Staff #1] and [Staff #2] did not attempted to calm her or redirect her behavior to leave the area. Instead [Staff #1] and [Staff #2] attempted to place her in a therapeutic hold, but it was unsuccessful. Staff ([Staff #1] and [Staff #2]) was able to get her down to the floor and [Staff #1] placed her knee on consumer, [Client #1] face and neck.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	08/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

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V 517	Continued From page 7	V 517		

Consumer, [Client #1] asked [Staff #1 to get off her face and neck because she could not breathe. [Staff #1] did not get off her face and neck due to consumer [Client #1] having [Staff #1's] hair in her hand. Consumer stated as she released [Staff #1's] hair, [Staff #1] remained on her face and neck.

[Client #2], Consumer: 7/14/2020:
Consumer, [Client #2], reported that on 7/13/2020 around 8:30pm, after [Client #1] was redirected by staff no to go on the opposite side of the unit, but [Client #1] did so anyway. [Client #1] began punching the walls due to being angry. Staff ([Staff #1 and Staff #2]) immediately attempted to place [Client #1] in a therapeutic hold. [Staff #2] grabbed [Client #1's] legs while staff [Staff #1] placed her knee on [Client #1's] neck. [Client #1] began pulling [Staff #1's] hair because consumer [Client #1] could not breathe; as consumer [Client #1] yelled out, she was unable to breathe multiple times. Nurse, [Licensed Practical Nurse (LPN)] informed [Staff #1] to remove her knee from [Client #1's] neck and assisted with removing [Staff #1] from [Client #1]. [LPN] then removed [Client #1] from the floor after comforting her. She also reported over hearing [Staff #1] talking to others about having her knee on [Client #1's] neck.

[Client #4], Consumer: 7/17/2020:
Consumer, [Client #4] reported that on 7/13/2020 around 8:30pm, she saw [Client #1] being escorted from the hallway by two staff ([Staff #1 and Staff #2]). [Client #4] stated [Client #1] then pulled [Staff #1's] hair and [Staff #1] put her knee in [Client #1's] neck. [Client #1] said she could not breathe. [Client #1] grabbed [Staff #1's] hair. [Staff #1] then put her knee on [Client #1's] neck; as they ([Staff #1 and Staff #2]) fell to the floor, attempting to place [Client #1] in a therapeutic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	08/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

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V 517	Continued From page 8	V 517		

hold. [Client #4] was unable to determine if [Staff #1's] knee being placed on [Client #1's] neck was intentional or not.

-Interview Section:

[Staff #1], Paraprofessional Staff: 7/15/2020: Staff, [Staff #1] reported that on 7/13/2020 around 8:30pm [Client #1] went into behavior (i.e. hit the walls continuously) due to being upset after a phone call with her guardian. [Staff #1] and [Staff #2] attempted to place [Client #1] in a therapeutic hold; to prevent her from harming herself. The therapeutic hold was unsuccessful, as [Client #1] grabbed and began pulling [Staff #1's] hair and they (staff, [Staff #1] and consumer, [Client #1]) fell to the floor. Nurse, [LPN] verbalized to [Client #1] to stop pulling staff, [Staff #1's] hair. [Staff #1] heard consumer, [Client #1] yell, she could not breathe, therefore staff, [Staff #1] removed her body completely from [Client #1]. [Staff #1] does not recall her knee being on [Client #1's] neck due her head being in a downward position since [Client #1] was pulling her hair. [Staff #1] stated that she does not recall making the following comment, 'yes, I had my knee on her neck because she ([Client #1]) had a handful of my hair and would not let go.'

[Staff #2], Paraprofessional: 7/16/2020: Staff, [Staff #2] reported that on 7/13/2020 around 8:30pm consumer was upset after being asked to complete a task (put the ice bin back in the freezer). [Client #1] began arguing with her peers, slammed doors and hitting walls with her fist. After being redirected to discontinue her the aggressive behaviors, [Client #1] continued to hit the walls. [Staff #1] and [Staff #2] then attempted to place [Client #1] in a therapeutic hold; to prevent her from harming herself. [Staff #1] and [Staff #2] were unable to successfully perform the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	08/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

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V 517	Continued From page 9	V 517		

therapeutic hold due to [Client #1] continuous kicking and pulling [Staff #1's] hair. This resulted in both staff ([Staff #1] and [Staff #2]) and [Client #1] falling to the floor. Staff, [Staff #2] does not believe [Staff #1's] knee being on [Client #1's] neck was intentional. As soon as [Client #1] released [Staff #1's] hair, [Staff #1] was able remove herself from [Client #1].

[Residential Service Supervisor(RSS)], RSS: 7/20/2020: [RSS] reported that on the date of 7/13/2020, he approached Oakwood D for a behavior. He saw [Staff #1] walk out of the unit, she appeared upset and was yelling 'yes, I had my knee on her neck because she ([Client #1]) had a handful of my hair and would not let go.' [RSS] stated that he redirected her verbal conduct and counseled her about the use of improper NCI+ techniques. He stated that [Staff #1] remained upset and verbalized that she did what she had to do to get the consumer off her. [RSS] stated that he reassigned [Staff #1] briefly, then sent her home of administrative suspension.

[LPN], Nurse: 7/16/2020: Nurse, [LPN] reported that on 7/13/2020 around 8:30pm, she observed [Client #1] hitting the wall and as a result [Staff #1] and [Staff #2] attempted to place [Client #1] in a therapeutic hold; to prevent [Client #1] from harming herself. The therapeutic hold was improperly performed; as [Client #1] hit and kicked staff ([Staff #1 and Staff #2]) to avoid being placed in a restraint. The therapeutic hold failed as [Staff #1], [Staff #2] and [Client #1] fell to the floor; after they fell, [Client #1] grabbed and pulled [Staff #1's] hair. While on the floor [Client #1] continued to kick and yelled out, she was unable to breathe and for [Staff #1] to remove her knee from her face. Nurse, [LPN] began to assist by placing her hand in [Client #1's] hand to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	08/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

(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 10	V 517		

release [Staff #1's] hair from [Client #1's] hand as she continuously asked [Staff #1] to remove her knee from [Client #1's] neck. [LPN] then was able to remove [Staff #1's] hair from [Client #1's] hand and [Staff #1] was able to remove herself from [Client #1].

-Physical Assessment for Abuse/Neglect/Exploitation
Client Name: [Client #1] Date: 7/13/20 Time: 2100 (9:00pm)
The above named client has checked by named nurse below and the following findings of the examination are written below: (2) reddened areas on L (left) side of upper body. (1) L side of neck 1 inch x 1/4 inch, (1) L side of chin just below cheek. Swelling/Redness noted to R (right) 2nd, 3rd, 4th finger. L thumb red/swollen, consumer c/o (complain) discomfort felt in thumb that extend to wrist L with movement. (3) light bruising/discoloration 3 mm (millimeter)-4 mm in size on L upper arm. Nurse Signature: [LPN]

Internal Investigation Findings: The inquiry findings for this allegation were found to be unsubstantiated for physical abuse due to the following reasons:

*[Staff #1's] actions were self-protecting measures.

*The physical findings on the client likely resulted from the failed therapeutic restraint and from the consumer,

[Client #1], punching the walls. By definition, abuse does not include injury accidentally sustained in self- protective measures.

*Several witnesses observed the incident and all statements are consistent with the events that were reported.

Actions Taken:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	08/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

(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 11 *Consumer will continue with PRTF treatment services. *[Staff #1] and [Staff #2] will return from suspension. *[Staff #2] and [Staff #1] will be reassigned to alternate work locations pending conclusion of external investigations related to this allegation. Both staff will participate in a debriefing with the Residential Director/NCI+ instructor regarding this incident. Each will be provided strategies to utilize in the future to help prevent similar outcomes with aggressive youth. Both staff will receive NCI+ refresher training. *NOVA (licensee) PRTF (Psychiatric Residential Treatment Facility) will continue to monitor for client safety according to all state and company policies and procedures. *NOVA PRTF will continue to report, investigate, and document all reports of abuse, neglect, or exploitation according to all state and company policies and procedures." Review on 08/14/2020 of the facility's In-service Training Report dated 07/22/2020 revealed: -Staff #1 and Staff #2 completed an in-service. -"Subject(s) Covered: Behavior Management, Least Restrictive Interventions, Prohibited NCI+ Techniques" and completed by the Director of Residential Services. Review on 08/14/2020 of the video of the date of the incident on 07/13/2020 revealed: -The beginning of the video staff #1 and staff #2 and client #1 were out of camera view but you could hear voices in the video. -LPN walked toward client #1 and asked for her to calm down and client #1 walked to the opposite hall. -Staff #1 and Staff #2 followed client #1 to the other hall.	V 517		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	08/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

(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 12	V 517		

-Client #1 started punching the wall and staff #1 and staff #2 attempted to restrain client #1 against a wall which was unsuccessful.
-Staff #1 had client #1 by her right arm pulling and yanking her arm into the commons area.
-Staff #1 grabbed client #1's legs and was trying to get her down to the ground and at that time client #1 grabbed staff #1's hair.
-Staff #2 was also grabbing client #1 trying to get client #1 into a restraint.
-Staff #2 was laying on the ground holding client #1's legs and staff #1 was laying on top of client #1.
-Client #1 was crying and yelled she could not breathe.
-The LPN was on her phone and then walked over and got on ground and was leaning into the area where staff #1 was on top of client #2.
-A consumer (client #2) walked over and was looking over staff and client once client #1 started yelling she could not breathe.
-Client #1 continued to yell and you could hear client #2 was also screaming and crying.
-You could hear someone saying "let go of her, let go of her."
-Client #1 let go of staff #1's hair and staff #1 got up and walked down the hall.

During interview on 08/13/2020 client #1 revealed:
-She had lived 2 months at the facility.
-She got upset because she had a bad phone call with her grandmother.
-She went to her room to process.
-She came out of her room and staff #2 told her to put the ice tray back into the freezer and she had not taken the ice out and she got mad.
-She went back to her room and slammed the door and started cussing.
-Staff #2 followed her to her room and was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	08/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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		

arguing with her.
-She went out of her room and went down another hall and started punching the wall.
-Staff #1 and staff #2 tried to "wrap" and then tried to put her in a safety hold.
-Everyone fell to the ground and staff #1 put her knee in my neck and on my face.
-She grabbed staff #1's hair.
-She kept telling staff #1 she could not breathe and to get off of her.
-The staff were never able to get her in a restraint because she was on the floor.
-Staff #1, Staff #2, the nurse and other consumers were present during the incident.

During interview on 08/13/2020 client #2 revealed:
-Staff #2 told client #1 to put the ice back and client #1 would not do it.
-Client #1 ran to her room because another consumer said something to client #1.
-Client #1 was cussing and staff #1 and client #1 were yelling back and forth to each other.
-Client #1 started punching the wall on another hall.
-Staff #1 and staff #2 tried to wrap client #1.
-Staff #2 had client #1's legs in the air.
-Staff #1 had her knee in client #1's neck and head.
-Client #1 started pulling staff #1's hair and client #1 was yelling she could not breathe.
-The LPN got staff #1 off of client #1.
-Staff #1 was mad.
-Staff #1 yelled that she "sure did put her knee in that b****'s neck."
-She had never seen anything like that before.
-She was next to client #1 screaming and crying telling staff #1 to get off of client #1's neck.

During interview on 08/14/2020 staff #1 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	08/14/2020

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V 517	Continued From page 14 -Client #1 was having a bad day and client #1 was upset with another consumer. -Client #1 made a call to her grandmother stating she wanted to fight someone. -She was doing medications and heard a loud noise. -Client #1 and staff #2 were arguing. -Client #1 went to another hall and she asked client#1 to get off of the hall. -Client #1 started to swing her arms and at that time staff #2 did not know how to do a restraint and she was trying to show staff #2 how to do the restraint. -Staff #2 was not getting how to do the restraint. -Client #1 grabbed her hair and staff #2 and the LPN could not get client #1 to let go of her hair. -Client #1 was controlling Staff #1's body because "...she was pulling my hair so hard." -Client #1 dug her nails into Staff #1's scalp and her hair came out. -Client #1 was "...yelling I was hurting her and I was on her." -She did not recall being on client #1 because client #1 was controlling her with her hair. -The LPN was present and trying to get client #1 to let go of Staff #1's hair. -She did not remember having her knee on client #1's neck. -If she did have her knee on client #1's neck it was not done intentionally. -They were sent home after the incident. -She did not recall saying anything after the incident outside in front of the RSS. -She did not recall saying she did put her knee in client #1's neck. -Her scalp was bleeding and her head was hurting after the incident. During interview on 08/14/2020 staff #2 revealed: -She had worked at the facility since February.	V 517		

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	MHL054-126	A. BUILDING: _____ B. WING _____	08/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FACILITY	2002 D & E SHACKLEFORD ROAD KINSTON, NC 28504

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V 517	Continued From page 15 -She had only worked at the facility for a few days. -Client #1 was upset and went to her room and was banging her fist in her room and yelling. -Client #1 continued to yell and staff #2 came to assist with client #1. -Client #1 started walking to another hall way that she was not allowed to go on. -Staff was trying to stop her and she started banging her fist on the wall. -Staff #1 told client #1 that if she did not stop banging her fist staff were going to have to put her in a restraint. -She and staff #1 tried to put her in a wrap and client #1 fought back. -Everyone fell to the ground and client #1 had staff #1's hair. -Staff #1's knee was on her and client #1 had staff #1's hair and staff #1 was trying to get up. -Every time staff #1 would try to get up client #1 would pull her back down on her. -Staff #1's knee being on client #1 was not done intentionally. During interview on 08/14/2020 the LPN revealed: -She was the nurse for the night time medications and it had been reported that client #1 was about to have a behavior. -She went to see what was going on with client #1. -She went to the commons area of the facility and she saw staff #2 standing at client #1's door way and the staff was pointing at client #1 and being very loud. -Client #1 came out of her room and walked to the opposite side and was hitting the walls. -Staff #2 was redirecting client #1 and tried to escort client #1 back. -Staff #2 had client #1's arms behind her back with her arms interlocked which was not how they	V 517		

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	MHL054-126	A. BUILDING: _____ B. WING _____	08/14/2020

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V 517	Continued From page 16	V 517		

were trained.
-Client #1 started fighting staff #2 and getting agitated and staff #1 went to assist.
-Client #1 got staff #1's hair as staff #1 and staff #2 were trying to restrain client #1.
-The restraint was a failed restraint.
-The three of them ended up coming from the hall way going into the commons area.
-Staff #1 and client #1 went down to the floor and client #1 was kicking and staff #2 was holding client #1's legs.
-She was calling the RSS and client #1 started yelling she could not breathe.
-Client #1 was yelling staff #1's knee was on her neck.
-She got on her knees to make sure the client #1 was ok.
-Staff #1's knee was on client #1's left side of her neck.
-She told staff #1 to remove her knee and staff #1's knee kept shifting from client #1's neck to her face.
-She was able to get her hand inside and push staff #1's knee off of client #1 and hover over client #1.
-As soon as she was able to get her hand inside she got staff #1's hair released and staff #1 walked away.
-Client #1 laid on the floor crying and she sat with client #1.
-She believed the Consumer Affairs Coordinator (CAC) and the Director of Residential Services completed the investigation.
-She had NCI+ training and CPI (Crisis Prevention Institute) training and as soon as she saw the escort on client #1 it was an improper escort from the beginning.
-She requested that both staff go back through NCI+ training.
-The staff were moved to different buildings after

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V 517	Continued From page 17	V 517		

the incident.
-The position of staff #1's knee bothered her because of the location of knee being so close to the corroded artery in the neck.
-It was really hard to see the knee on client #1's neck from the camera view.
-The way staff #1 was positioned you would not be able to fully see where the knee was during the restraint.

During interview on 08/14/2020 the RSS revealed:
-He was not in the facility during the time of the incident.
-He got a phone call from staff about client #1's behaviors and he was walking from another facility at the time of the incident.
-Staff #1 was coming out of the facility and stated she did have her knee in client #1's neck and she was upset.
-He corrected client #1 for her verbal reaction after the incident.
-Staff #1 and staff #2 were immediately told to leave the facility that night.
-Every staff had to be trained in NCI+ every 6 months.
-The staff are taught how to release hands from hair and are refreshed on all techniques.

During interview on 08/14/2020 the CAC revealed:
-She completed the internal investigations for the facility.
-The internal investigation was not substantiated because staff #1 did not intentionally place her knee on client #1's neck.
-Staff #1 was forced in the direction client #1 was pulling staff #1.
-Staff and client #1 fell to the floor due to client #1 grabbing staff #1's hair.

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	MHL054-126	A. BUILDING: _____ B. WING _____	08/14/2020

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V 517	Continued From page 18	V 517		

-Client #1 stated she was not hurt and was not harmed.
-What the nurse had stated was not a true accurate description of events that occurred during that incident.
-The camera was glitchy and she stated she went under the staff and none of that happened.
-When she viewed the camera footage was the nurse was there and she could not see the child's face at all.
-The camera's do have audio and she was not able to bring up the audio when she reviewed the camera footage.

During interview on 08/14/2020 the Program Director revealed:
-She did not agree with the deficiency due to the client having the staff's hair and being unable to tell if the staff's knee was on the client.
-The client was able to breathe because she was yelling she could not breathe.
-The way the nurse stated the events took place did not happen that way.
-The staff involved in the incident had not had NCI+ refresher course since the incident.
-They did complete coaching with the Director of Residential Services.
-The client was pulling the staff's hair so hard it was very difficult to get a child in a restraint in that type of incident.

Review on 08/14/2020 of the Plan of Protection completed by the Program Director dated 08/14/2020 revealed:
"-What will you immediately do to correct the above rule violation in order to protect clients from further risk or additional harm? NOVA will make immediate arrangements for [Staff #2], Paraprofessional and [Staff #1], Paraprofessional

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V 517	Continued From page 19 to attend an NCI+ Refresher training before being allowed to work their next shift. That training has been arranged to take place this evening, 8/14/2020. Neither staff may work with consumers until they successfully complete the training. -Describe your plans to make sure the above happens. The training has been scheduled to take place this evening upon their arrival to work. The Program Director has provided strict instructions to the Residential Services Supervisor to not allow them to return to work without having completed the training." Client #1 was a 15 year old female admitted with diagnoses to include Conduct Disorder, Unspecified, Severe, Major Depressive Disorder, Recurrent, severe without Psychotic features, Cannabis Abuse, Uncomplicated, Mild. Around 8:30 pm on 07/13/2020 Client #1's behaviors escalated from verbal to physically punching the wall. Staff #1 and staff #2 attempted to place client #1 in a therapeutic hold and grabbed and pulled client #1 into the commons area and they all fell to the floor. During this incident, staff #1 was observed placing her knee on client #1's neck and face until client #1 screamed out that she could not breathe. The LPN intervened and attempted to place her hand between client #1's neck and staff #2's knee. After the incident client #1 was assessed and had injuries that included reddened areas on the left side of the upper body, neck and chin and swelling, swelling/redness to right 2nd, 3rd and 4th finger, discomfort to left thumb and light bruising/discoloration on left upper arm. The failure of staff #1 and staff #2 to use proper de-escalation and restrictive intervention techniques resulted in client #1's injuries and	V 517		

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V 517	Continued From page 20 being able to not breathe for a period of time. This constitutes a Type A1 deficiency for serious harm and must be corrected within 23 days. An administrative penalty of $1500.00 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 517		