Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL059-072	A. BUILDING: _____ B. WING _____	C 09/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEAR SKY GROUP HOME	55 RAILROAD STREET MARION, NC 28752

(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 September 2, 2020. The complaints were substantiated (Intake #NC00165614 and #NC165199). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure 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	PCPs have all been revised to meet the measures and expectations of the rule. 9/15/2020	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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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 to address clients' needs affecting 3 of 3 former clients (FC#1, FC#2 and FC#3). The findings are: Review on 6/11/20 of the record for FC#1 revealed: -Date of Admission: 4/3/20. -Date of Discharge: 4/29/20. -Age: 14. -Diagnoses: Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, rule out Disruptive Mood Dysregulation Disorder, and rule out Autism Spectrum Disorder. -An assessment dated 5/9/19 with an addendum completed on 2/20/20 indicated a history of verbal and physical aggression, the use of illegal substances, engagement in illegal activity, sexualized behaviors, elopement, idolization of gang culture, and consistent defiance of basic rules and structure. -A treatment plan dated 3/17/20 and updated on 4/20/20 did not include the development and implementation of strategies to address illegal substance use, sexualized behaviors, elopement behaviors, the idolization of gang culture, or the defiance of rules. Interview on 7/30/20 with the Legal Guardian for FC#1 revealed: -She was told that substance abuse counseling would be provided at the facility.	V 112	PCP's have been revised to state individual Strategies and goals reflection of the team. These (3) cases were not in our care long enough to really develop goals that reflect exactly where they need to be. This area of deficiency has been corrected and ready for Correction Action Audit of compliance. 9/05/2020	

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V 112	Continued From page 2 -FC#1 did not receive any type of substance abuse treatment during his admission. Review on 6/11/20 of the record for FC#2 revealed: -Date of Admission: 4/14/20. -Date of Discharge: 4/30/20. -Age: 16. -Diagnoses: Attention Deficit Hyperactivity Disorder, and rule out Bipolar I Disorder. -An assessment dated 1/8/20 with an addendum completed on 4/10/20 indicated a history of verbal and physical aggression which included numerous instances of property damage, assaults on peers, biting and spitting on others, substance abuse, and elopements. -A treatment plan dated 4/2/20 and updated on 4/22/20 did not include the development and implementation of strategies to address elopement behaviors and did not include individualized interventions to manage aggressive behaviors. Review on 6/10/20 of the facility Incident Reports for FC#2 revealed the following: -On 4/22/20 FC#2 became enraged, began cursing and broke the facility door off the hinges. -On 4/28/20 FC#2 was bullying a younger client and struck the client in the face with a notebook. -On 4/29/20 a client reported that FC#2 slapped him in the face; FC#2 became upset with a staff member and cursed at her in front of other clients; FC#2 was verbally aggressive and threatened another client. -On 4/30/20 FC#2 became enraged and threatened to physically harm the Facility Administrator; Local Law Enforcement responded and FC#2 was taken to the local emergency room to be evaluated for involuntary commitment (IVC). -There was no evidence of interventions by facility	V 112	Very dangerous client. dangerous to staff and peers. Anytime he spoke with the Tribal treatment team he became enraged. We were left to pick up the pieces and de-escalate.	9.15.20

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V 112	Continued From page 3 staff to de-escalate or minimize the occurrence of out of control behaviors for any of the incidents Interview on 6/10/20 with the Legal Guardian for FC#2 revealed: -She believed facility staff did not utilize any de-escalation techniques. -She stated "[The Facility Administrator] told me he had to walk on eggshells around [FC#2] which was concerning because it's a level III group home and he should have skills to know how to handle kids with behaviors ..." Interview on 6/19/20 with the Local Management Entity (LME) Complex Care Manager for FC#2 revealed: -She stated "We were clear about what behaviors [FC#2] had in his past and it was clearly written in his CCA (Comprehensive Clinical Assessment) which we sent to the facility prior to his admission. I don't know if they even read the intake paperwork." -The facility did not provide "any type of documentation of de-escalation interventions ..." for FC#2. -She stated, "If Clear Sky had responded differently towards [FC#2] and tried to use de-escalation techniques, then I believe this would have had a good outcome." Review on 7/14/20 of the record for FC#3 revealed: -Date of Admission: 5/28/20. -Date of Discharge: 6/8/20. -Age: 16. -Diagnoses: Adjustment Disorder with disturbance of Conduct, Post Traumatic Stress Disorder unspecified, and Cyclothymic Disorder. -An assessment dated 5/4/20 with an addendum completed on 5/21/20 indicated a history of verbal	V 112	It is true, [redacted] is a certified NC1+ instructor and well versed in de-escalation. This is a criminal with criminal behaviors. This is a complete false statement. This about this case are staff not clarified. He would go beyond dangerous at every meeting with his Previous clinicians. Our facility staff was left to pick up the pieces and de-escalate. 9/15/2020	

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V 112	Continued From page 4 and physical aggression, illegal substance use, simple assault and assault with a deadly weapon, endangering animals, allegations against staff and breaking house rules at previous placements. -A treatment plan dated 6/1/20 did not include the development and implementation of strategies to address aggressive behaviors, or substance use. -A Clear Sky Behavioral Comprehensive/Psychosocial Assessment Addendum dated 6/10/20 revealed FC#3 displayed "moderate to severe aggression AEB (as evidenced by) getting into physical altercations with another peer with no identified trigger ...Difficulties forming a trusting relationship with caretakers, safety concerns AEB climbing into ceiling tiles and stating he got shocked ...Deficits to manage personal health, welfare and safety without intense supervision ...[FC#3] picked up used cigarettes on the ground and lit them within the home to smoke ...was non-compliant with the Level III group home's requirements and structure ...He would leave the group home's property at his leisure." Interview on 7/17/20 with the Legal Guardian for FC#3 revealed: -The police were called to the facility every day during FC#3's admission. -FC#3 had numerous elopements from the facility and several altercations with other clients. -She stated, "The last straw was a physical altercation with a peer." Interview on 8/6/20 with the Facility Administrator revealed: -Treatment plans were initiated by the Associate Professional (AP) and Qualified Professional (QP). -He stated, "They do all of the PCP's	V 112		

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V 112	Continued From page 5 (Person-Centered Profile's)." Interview on 8/6/20 with the Associate Professional (AP) revealed: -The Facility Administrator was responsible for client treatment plans. -She stated "We usually have a CCA prior to admission, but sometimes we just have the addendum and base the determination off what the clinician is telling us. I am the one that updates the percentages of which goals have been met. I don't do the writing of the PCP ..." Interview on 8/6/20 with the Qualified Professional (QP) revealed: -The PCP was the responsibility of the Associate Professional. -He stated "I can only review what is provided to me. Lots of times we just get an addendum and sometimes we find that providers aren't forthcoming with client behaviors." -Facility staff could not develop a proper plan for clients without all the documentation. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type B rule violation and must be corrected within 45 days.	V 112		
V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be	V 293		

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V 293	Continued From page 6 awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to a community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care.	V 293		

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V 293	Continued From page 7 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide services designed to minimize the occurrence of behaviors related to functional deficits, ensure safety and de-escalate out of control behaviors affecting 3 of 3 former clients (FC#1, FC#2 and FC#3). 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 to address clients' needs affecting 3 of 3 former clients (FC#1, FC#2 and FC#3). CROSS REFERENCE: 10A NCAC 27G .1708 Transfer or Discharge (V300) Based on record reviews and interviews the facility staff failed to meet with existing child and family teams, or other required persons to make service planning decisions prior to the transfer or discharge of the adolescent from the facility affecting 3 of 3 former clients (FC#1, FC#2 and FC#3). Interview on 8/6/20 with the Associate Professional (AP) revealed: -Staff were trained through National Crisis Interventions Plus (NCI+). -Staff were instructed in "de-escalation techniques and some areas of defense, such as how to get away from a dangerous situation without causing harm to the clients." -The group home was a "no touch facility".	V 293	Clear Sky Behavioral had failed To review the Annual CCA and only viewed the addendum on several occasions. Changes have been adopted that require all documentation to be present prior to Intake discussions. CSB Administrator is also a NCI+ Instructor and well versed in de-escalation of behaviors. In an instance where Clients portray criminalistic instincts and behaviors. it is Many times impossible to gain trust to develop a relationship that can move the treatment scale in a positive direction. When these clients present Themselves as a danger to peers and staff we look to find alternate arrangements for them. A More comprehensive review of the intake documents have been implemented with a focus on clients that have a more profound ability To be served.	9/10/20

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V 293	Continued From page 8 Interview on 8/6/20 with the Facility Administrator revealed: -Clients were always supervised. -All staff received de-escalation training through NCI+. -He was a certified NCI+ instructor. -He was the only employee trained to use restrictive intervention. -He did not feel comfortable allowing staff to use restrictive interventions. -Verbal de-escalation was effective most of the time. -He stated, "If I am not available, the police respond." -The facility was located next to a police station. Review on 9/1/20 of the Plan of Protection completed and signed by the Facility Administrator on 9/1/20 revealed: -"What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? Clear Sky Behavioral, LLC (Limited Liability Company) is currently conducting comprehensive reviews of all treatment plans to individualize strategies to treat the resident. We are basing the review on the diagnosis and presenting behaviors since admission. In the future, new resident PCP's (Person-Centered Profile's) will be written with strategies from previous documented behaviors relative to the most current annual CCA (Comprehensive Clinical Assessment). Describe your plans to make sure the above happens. We will seek to extend training to AP's that are working to improve documentation standards. Clear Sky Behavioral is currently conducting these reviews during the scheduled CFT (Child	V 293		

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V 293	Continued From page 9 and Family Team) meetings for September. All updating and meeting standards set by the conclusion of the month." Review on 9/2/20 of the Addendum to the Plan of Protection completed and signed by the Facility Administrator on 9/2/20 revealed: -"What will you immediately do to correct the above rule violation in order to protect clients from further risk or additional harm? Our staff are well-versed in de-escalation verbally. We have not been placed in a position in 3 years to restrain a child and that is very commendable. The one practice that we will seek to improve is to review the annual CCA for more comprehensive review. We have been trusting the addendum for present behaviors and this has failed on several occasions. We have made revisions to the Initial Assessment Tool that reflects that the annual CCA has been reviewed and accepted as determination of the clients acceptance. Describe your plans to make sure the above happens. We have revised our initial screening document to include a more comprehensive review prior to acceptance. This includes but not limited to gang related activity. In these cases, it is virtually impossible to gain the trust of the resident to want to better their circumstance. We are further considering training key employees in restraint but this has not been adopted as of yet." Former Clients #1, #2 and #3 had varying psychiatric diagnoses and histories of trauma. Their behaviors included verbal and physical aggression, property damage, engagement in illegal activity, elopement, and idolization of gang culture. Facility staff failed to develop and implement strategies to address clients' needs.	V 293		

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V 293	Continued From page 10 FC#1, FC#2 and FC#3 were involved in numerous altercations with staff and peers. There was no evidence that facility staff utilized any type of de-escalation techniques. FC#1, FC#2 and FC#3 were abruptly discharged from the facility due to staff's inability to manage their behaviors. FC#1 spent twenty-seven days at the facility and was then sent home on therapeutic leave. FC#1 was discharged from the facility while he was at home on therapeutic leave. FC#2 spent seventeen days at the facility and was then taken to the local emergency room (ER) to be evaluated for an involuntary commitment (IVC). FC#2 did not meet IVC criteria and facility staff failed to pick him up from the ER and would not allow him to return to the facility. FC#2 went to a facility-based crisis center and was eventually placed in a Psychiatric Residential Treatment Facility (PRTF). FC#3 spent twelve days at the facility and then his Legal Guardian received an e-mail from the QP which indicated FC#3 was being discharged and would need to be picked up by 12:00 pm the next day. FC#3 went to a facility-based crisis center while alternative placement was sought. FC#1, FC#2 and FC#3 were discharged from the facility without having proper services in place to meet their individual needs. These failures are considered detrimental to the health, safety and welfare of clients and constitute at 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 beyond the 45th day.	V 293	Clear Sky Behavioral had a notarized agreement that stated anything NOT disclosed or that became a danger to other residents or staff would comply with immediately moving them from the facility. This was signed and agreed by guardian at intake. We made no surprise discharge of efforts to derail treatment efforts. Our viewpoint was only to keep our other clients safe from harm. Assault, destruction of property, and verbal threats are crimes in accordance with NC Law. These (3) cases included and presented all 3 of these criteria. We are confident that we prevented others from being injured with the decisions that were made.	9/15/2020
V 300	27G .1708 Residential Tx. Child/Adol - Trans or dischg 10A NCAC 27G .1708 TRANSFER OR	V 300		

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V 300	Continued From page 11 DISCHARGE (a) The purpose of this Rule is to address the transfer or discharge of a child or adolescent from the facility. (b) A child or adolescent shall not be discharged or transferred from a facility, except in case of emergency, without the advance written notification of the treatment team, including the legally responsible person. For purposes of this Rule, treatment team means the same as the existing child and family team or other involved persons as set forth in Paragraph (c) of this Rule. (c) The facility shall meet with existing child and family teams or other involved persons including the parent(s) or legal guardian, area authority or county program representative(s) and other representatives involved in the care and treatment of the child or adolescent, including local Department of Social Services, Local Education Agency and criminal justice agency, to make service planning decisions prior to the transfer or discharge of the child or adolescent from the facility. (d) In case of an emergency, the facility shall notify the treatment team including the legally responsible person of the transfer or discharge of the child or adolescent as soon as the emergency situation is stabilized. (e) In case of an emergency, notification may be by telephone. A service planning meeting as set forth in Paragraph (c) of this Rule shall be held within five business days of an emergency transfer or discharge. This Rule is not met as evidenced by: Based on record reviews and interviews the	V 300	We have revised the Immediate Discharge Agreement To include an Emergency CPT within 12 hours of NOTICE. If the team decides that discharge and Level changes are the route to take, the liability will shift to that of the guardian to ensure damages, bodily injury and other concerns have been taken into consideration within the parameters of continued treatment. The Immediate Discharge document has been removed from use at the time of intake in an effort to bring compliance to this rule. 9/15/20	

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V 300	Continued From page 12 facility staff failed to meet with existing child and family teams, or other required persons to make service planning decisions prior to the transfer or discharge of the adolescent from the facility affecting 3 of 3 former clients (FC#1, FC#2 and FC#3). The findings are: Review on 6/10/20 of the facility's Immediate Discharge Agreement revealed: -A client could be immediately discharged from the facility for the following reasons: -Failure to disclose complete details of a client's prior street gang activity, sexualized behaviors, or substance abuse. -Failure to disclose that family members of the client resided in the same county as the facility. -Failure to disclose that family members of the client had an extensive criminal history. -If a client became an imminent danger to himself, or others in the facility. -If a client assaulted another peer, or staff member. -A client would need to be picked up from the facility within 12 hours of the immediate discharge notification. Review on 6/11/20 of the record for FC#1 revealed: -Date of Admission: 4/3/20. -Age: 14. -Discharged: 4/29/20. -Diagnoses: Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, rule out Disruptive Mood Dysregulation Disorder, and rule out Autism Spectrum Disorder. -A discharge summary dated 4/29/20 revealed "[FC#1] has made little to no progress in the minimal time he has been in the program ...His desire to glorify the street gang lifestyle with no	V 300	This docum was created to ensure that guardians were forth right in disclosing all behaviors at intake. We have removed this docum and it no longer states Immediate Discharge. It has been revised to request emergency CFT during times of crisis. 9/15/2020	

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	MHL059-072	A. BUILDING: _____ B. WING _____	C 09/02/2020

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V 300	Continued From page 13 DJJ (Department of Juvenile Justice) support or true judicial consequences makes it impossible for us, at this point, to gain his trust during the treatment process. He refused to complete basic treatment objectives ...He regularly curses at staff and refuses to follow simple prompts with any level of effectiveness. [FC#1] is very volatile and poses an imminent safety risk ..." Interview on 6/18/20 with the Local Management Entity (LME) Complex Care Manager for FC#1 revealed: -On 4/20/20 facility staff suggested therapeutic leave for FC#1, so his Mother took him home. -FC#1 was to be on leave for 7 days and then a conference call was to take place to discuss his behaviors. -Facility staff were to determine if leave would be extended at the time of the conference call. -The following week FC#1's Mother was unaware of a plan, or date for FC#1 to return to the facility. -She called the facility and they didn't return her call for several days. -On 5/1/20 the Facility Administrator and the Qualified Professional (QP) called to inform her that FC#1 had been discharged. -She was not involved in the decision for FC#1 to be on therapeutic leave, or to be discharged. Interview on 7/30/20 with the Legal Guardian for FC#1 revealed: -On 4/20/20 she thought she was going to the facility for the first Child and Family Team (CFT) meeting. -When she and her husband arrived at the facility, they were informed that they needed to take FC#1 home for seven days. -She stated, "We never even had a CFT meeting, we drove all the way up there and it wasn't a meeting." -FC#1 was told by facility staff to take his	V 300	a PRTF bed was locate for FC#1 and the mother refused to accept that recommendation. At this time, we opted to discharg the case for going against clinical recommendation. The mother was reluctant for him to come to CSS due to an immediate family member being in the program. This quickly eroded the success of the other child and we felt a short term separation could	

9/15/2020

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V 300	Continued From page 14 personal belongings with him when he went home on leave. -She stated, "It was supposed to be for 7 days, then 7 days lead to 10 days." -She repeatedly called the facility while FC#1 was at home, but nobody would answer the phone. -FC#1 did not return to the facility. Review on 6/11/20 of the record for FC#2 revealed: -Date of Admission: 4/14/20. -Age: 16. -Discharged: 4/30/20. -Diagnoses: Attention Deficit Hyperactivity Disorder, and rule out Bipolar I Disorder. -A discharge summary dated 4/30/20 revealed "[FC#2] made no progress while placed at CSB [Clear Sky Behavioral]. [FC#2] began using gang language and was actively recruiting other clients into his gang ...He became increasingly disruptive within the facility and encouraged other clients to be disruptive and disrespectful towards staff.'" Review on 6/10/20 of the local Emergency Room Report for FC#2 dated 4/30/20 through 5/2/20 revealed: -FC#2 did not meet criteria for involuntary commitment (IVC). Interview on 6/19/20 with the LME Complex Care Manager for FC#2 revealed: -FC#2 was only at the facility for a short time. -FC#2 was discharged for behaviors that "fit what the level III group home is supposed to take care of." -She stated, "It was a very abrupt discharge...He was just dropped off at the ER (emergency room)." -The facility staff sent FC#2 to the local emergency room where he was evaluated and	V 300	Slow whether it was having them both in the facility or not caused the problem. It was shown to be the case, we located a PRTF bed and mom decided to not pursue this option. Level III facilities are not equipped to handle grown 16-17 year olds with a lifetime family history of gang related activity making assaults, threats, and property damage for statements made by the treatment team during a CFT. This case had a lot of hidden concerns that had not been shared with the facility. 9/15/2020	

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V 300	Continued From page 15 didn't require any interventions. -She felt the facility "just refused to take him back." -FC#2 went to a facility-based crisis center while placement was sought. Interview on 6/23/20 with the Legal Guardian for FC#2 revealed: -She received an e-mail from the facility on 4/29/20 at approximately 8:00 pm. -The e-mail was titled Immediate Discharge Notice and indicated that FC#2 had to be out of the facility within 12 hours. -On 4/30/20 the Facility Administrator and the QP called to notify her that FC#2 had been taken to the local emergency room and was IVC'd for making homicidal and suicidal comments. -FC#2 did not meet IVC criteria and was discharged from the local emergency room. -The emergency room staff made several attempts to call the facility to have FC#2 picked up, but nobody answered the phone. -The Facility Administrator and the QP denied that the emergency room attempted to call the facility and claimed that they had no missed calls. -FC#2 was accepted at a Psychiatric Residential Treatment Facility (PRTF) but the bed would not be available until 5/4/20. -She requested that FC#2 be allowed to return to the facility for two nights while he waited on the available bed. -The Facility Administrator and the QP refused her request. -FC#2 was taken to a crisis center where he remained for two nights until the bed was available at the PRTF. Review on 7/14/20 of the record for FC#3 revealed: -Date of Admission: 5/28/20.	V 300	CSB Administrator acknowledges That we had refused to pick him up at the hospital. Threats had been made to peers and staff and this resident has family deep rooted in serious gang activity. He was not at all interested in treatment nor bettering himself. He was a criminal with criminal behaviors. Loyalty or trust could not be developed in this case. We made efforts to discuss and work through problems and behaviors. The inability to be safe and not hurt others was ultimately his decision. We want success for all residents and a ability for all to feel welcome. Some just don't feel the same way. 9/15/2020	

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V 300	Continued From page 16 -Age: 16. -Discharged: 6/8/20. -Diagnoses: Adjustment Disorder with disturbance of Conduct, Post Traumatic Stress Disorder unspecified, and Cyclothymic Disorder. Review on 7/17/20 of an email sent from the QP at 10:17 pm on 6/8/20 to the Legal Guardian and DJJ Representative for FC#3 revealed: -"We are at a point where we are not going to be able to further serve [FC#3] ...Per our immediate discharge notice, we are requesting for him to be picked up by 12pm tomorrow..." Interview on 7/17/20 with the Legal Guardian for FC#3 revealed: -She signed an Immediate Discharge Agreement when FC#3 was admitted to the facility. -She stated "We took a leap of faith and didn't really have a choice in the matter but to sign the form because [FC#3] had nowhere else to go..." -FC#3 was at the facility for a total of twelve days. -While at the facility, FC#3 had numerous altercations with peers. -On 6/8/20 at 10:17 pm, she received an e-mail from the facility which indicated FC#3 was being discharged and would need to be picked up by 12:00 pm the next day. -FC#3 was brought to a crisis center and then placed in a PRTF. Interview on 8/6/20 with the Facility Administrator revealed: -An Immediate Discharge Agreement was signed by the client's legal guardian at the time of admission. -FC#1, FC#2 and FC#3 displayed behaviors that met the criteria for an immediate discharge from the facility. -FC#1's Mother was informed that a higher level	V 300	Immediate Discharge Agrement was drafted, notarized, and signed by guardian at intake. It was not a surprise to any of the guardians that this was utilized. To refute the complaint and offer a version of the story they used is unfair to the facility Trying TO house clients that are not equipped to be safe in unlocked facilities. We have made adjustments to the intake process. and have even made staffing changes with our clinicians to ensure we are working very hard to serve clients at this level! 9/15/2020	