

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mh1041-818</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/18/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SUCCESSFUL TRANSITIONS, LLC RESIDENTIAL CAF</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1458 LONDON DRIVE HIGH POINT, NC 27262</b>
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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 000	<p>INITIAL COMMENTS</p> <p>A complaint survey was completed on September 18, 2020. One complaint was substantiated and one complaint was unsubstantiated (intake #NC00165165 and NC00165378 respectively). A Deficiency was cited.</p> <p>This facility is licensed for the following service category:</p> <p>- 10A NCAC 27G .1700: Residential Treatment Staff Secure for Children or Adolescents</p>	V 000		
V 296	<p>27G .1704 Residential Tx. Child/Adol - Min. Staffing</p> <p>10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS</p> <p>(a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times.</p> <p>(b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows:</p> <p>(1) two direct care staff shall be present for one, two, three or four children or adolescents;</p> <p>(2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and</p> <p>(3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents.</p> <p>(c) The minimum number of direct care staff during child or adolescent sleep hours is as follows:</p> <p>(1) two direct care staff shall be present and one shall be awake for one through four</p>	V 296		

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

Division of Health Service Regulation

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V 296	<p>Continued From page 1</p> <p>children or adolescents;</p> <p>(2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and</p> <p>(3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents.</p> <p>(d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan.</p> <p>(e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan.</p> <p>This Rule is not met as evidenced by: Based on interview, record review and observation the facility staff failed to ensure two direct care staff were present, the minimum number required, when clients were present and awake in the facility, for two (client #1 and client #2) of four clients audited. The findings are:</p> <p>Review on 6-4-20, 6-10-20 and 9-16-20 of client #1 ' s facility record revealed he was: - admitted 5-1-20 - 14 years old</p>	V 296		

Division of Health Service Regulation

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V 296	<p>Continued From page 2</p> <ul style="list-style-type: none"> <li>- diagnosed with:               <ul style="list-style-type: none"> <li>- Post Traumatic Stress Disorder</li> </ul> </li> <li>-Unspecified               <ul style="list-style-type: none"> <li>- Other Persistent Mood Disorder</li> <li>- Borderline Traits</li> </ul> </li> <li>Admission Assessment 4-9-20:               <ul style="list-style-type: none"> <li>- aggression towards family and peers</li> <li>- property destruction</li> <li>- anti-social behaviors</li> <li>- Impulsivity, lying, abandonment and oppositional issues</li> <li>- discharged 8-31-20</li> </ul> </li> <li>Review on 6-4-20 and 6-9-20 of client #2 ' s facility record revealed he was:               <ul style="list-style-type: none"> <li>- admitted 12-6-19</li> <li>- 14 years old</li> <li>- diagnosed with:                   <ul style="list-style-type: none"> <li>- Oppositional Defiant Disorder</li> <li>- Conduct Disorder</li> <li>- Cannabis Abuse</li> </ul> </li> <li>- Admission Assessment 9-26-19:                   <ul style="list-style-type: none"> <li>- admits he needs help with anger</li> <li>- fighting and other aggressions</li> <li>- obsessed with sexual issues</li> <li>- endorses hallucinations when angry and out of control</li> <li>- discharged 6-12-20</li> </ul> </li> </ul> </li> <li>Review on 6-4-20 of staff #1 ' s personnel record revealed:               <ul style="list-style-type: none"> <li>- hired 1-23-17</li> <li>- position:                   <ul style="list-style-type: none"> <li>- Paraprofessional Direct Care Staff</li> </ul> </li> </ul> </li> <li>Review on 6-4-20 of former staff #2 ' s personnel record revealed:</li> </ul>	V 296		

Division of Health Service Regulation

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V 296	<p>Continued From page 3</p> <ul style="list-style-type: none"> <li>- hired 1-30-09</li> <li>- position:               <ul style="list-style-type: none"> <li>- Paraprofessional Direct Care Staff</li> </ul> </li> </ul> <p>Review on 6-4-20 of staff #3 ' s personnel record revealed:</p> <ul style="list-style-type: none"> <li>- hired 4-20-20</li> <li>- position:               <ul style="list-style-type: none"> <li>- Paraprofessional Direct Care Staff</li> </ul> </li> </ul> <p>Review on 5-13-20 of incident reports involving client #1 and client #2 revealed an event just after midnight on 5-4-20:</p> <ul style="list-style-type: none"> <li>- client # 1 and client # 2 had left the facility AWOL (absent without leave)</li> <li>- the Qualified Professional (QP) was called by staff at 3:00 am to inform her the clients were gone</li> <li>- staff #2 arrived at 3:00 am and noticed a bedroom window was open</li> <li>- "upon going in his room (noticed) he was missing"</li> </ul> <p>Observation of the facility and grounds between 2:45 pm and 3:35 pm on 9-11-20 and interview on 9-14-20 with staff #1 revealed:</p> <ul style="list-style-type: none"> <li>- The office door inside the facility is located at the end of a hallway, approximately 25 feet from the living room</li> <li>- Directly down the hallway from the office to the living room is the couch, that was used by staff #1, to sleep on when client #1 and client #2 left the facility and drove away in the facility mini-van 5-3-20/5-4-20. From the couch, the office door is in a straight line of sight.</li> <li>- the street is crowded with parked cars</li> <li>- client #1 and client #2 ' s bedroom windows</li> </ul>	V 296		

Division of Health Service Regulation

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V 296	<p>Continued From page 4</p> <p>are located approximately 5-7 feet from the ground, creating an easy exit but a more difficult entry point.</p> <p>Review on 9-11-20 of the document titled: "Staff Schedule RF (Residential Facility) Level III London" revealed:</p> <ul style="list-style-type: none"> <li>- Staff #3 was scheduled to work from 4:00pm to midnight on 5-3-20</li> <li>- Staff #1 was scheduled to work from 10:00pm on 5-3-20 until 6:00am on 5-4-20</li> <li>- Former Staff #2 was scheduled to arrive at midnight on 5-3-20 to relieve staff #3 and work until 8:00am on 5-4-20.</li> </ul> <p>Interview on 9-15-20 with client #2 revealed:</p> <ul style="list-style-type: none"> <li>- on the night of 5-3-20, staff #3 left when his shift was over</li> <li>- former staff #2 failed to show up before staff #3 left the facility</li> <li>- staff #1 was designated as the sleep staff, and was asleep on the couch in the living room</li> <li>- the office door was open</li> <li>- the facility van keys were in the office on the desk</li> <li>- he and client #1 went in the office and got the van keys</li> <li>- he and client #1 returned to his room</li> <li>- he and client #1 exited the facility through his bedroom window, which is located near the front of the facility</li> <li>- he and client #1 drove the facility van to a nearby town (more than 60 miles away from the facility)</li> <li>- they left the van in a retail store parking lot and called his father</li> <li>- his father came and picked them up around 5:00am</li> </ul>	V 296		

Division of Health Service Regulation

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V 296	<p>Continued From page 5</p> <ul style="list-style-type: none"> <li>- his father then called the group home to tell them where they were</li> </ul> <p>Interview on 9-14-20 with staff #1 revealed:</p> <ul style="list-style-type: none"> <li>- "Maybe an average, at best once or twice in a month," a staff person works alone at the facility</li> <li>- on 5-3-20 he arrived at approximately 9:50pm to begin his shift</li> <li>- his second staff person was there when he laid down to sleep on the couch, about 11:30pm</li> <li>- he guessed that the other staff left when his shift ended, at midnight</li> <li>- former staff #2 was supposed to be there at midnight.</li> <li>- "When I woke back up, it was about 3:00am and [former staff #2] wasn ' t there."</li> <li>- "I noticed [client #1] and [client #2] were gone."</li> <li>- "I ... didn ' t know they had taken the van. We didn ' t find that out until the next morning."</li> <li>- "I think [former staff #2] ' s car broke down. If I had known, I could ' ve stayed awake</li> <li>- "What we ' re supposed to do (if we are going to be late) is call a supervisor. If they can ' t find someone to come in, they ' ll come in themselves."</li> <li>- both staff #3 who left at midnight, and former staff #2 were supposed to call a supervisor.</li> <li>- "If [former staff #2] had called (the facility), it would ' ve woken me up. I think she called [QP], I think, but I ' m not sure."</li> <li>- When he woke up the facility keys were next to him, but not the van keys</li> <li>- "I don ' t know if the van key was left with me when he (staff #3) left, or if it was in the office and they (client #1 and client #2) got the keys from next to me and opened the office to get the van keys. When staff aren ' t in the office, we</li> </ul>	V 296		

Division of Health Service Regulation

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V 296	<p>Continued From page 6</p> <p>usually leave it locked unless we can see the door from where we are in the facility."</p> <p>Attempts to interview Former Staff #2 on multiple dates was unsuccessful</p> <p>Attempts to interview client #1 were unsuccessful due to his being involuntarily committed to a psychiatric unit at a regional facility.</p> <p>Interview on 9-16-20 with client #1 ' s Father and Legal Guardian (F/LG) revealed:</p> <ul style="list-style-type: none"> <li>- Client #1 stole the group home minivan a few days after he was admitted</li> <li>- "[client #1] was the leader ..."</li> <li>- client #1, "got into a lot of trouble while at the group home, threatening staff, cursing people out, bullying other clients. Almost every week I was getting calls about things he was doing."</li> <li>- despite client #1 ' s issues, the group home had staffing problems</li> <li>- "their supervision is lacking. My question was, ' when he got in the office and got the keys, where was the staff ' ?"</li> <li>- "When I was there (visiting his son) more than once, I only saw one staff there." -dates and times not reported</li> <li>- "I know my son is a difficult child, but that ' s what the group home staff are for."</li> </ul> <p>Interview on 9-16-20 with staff #3 revealed:</p> <ul style="list-style-type: none"> <li>- he worked on Sunday, 5-3-20</li> <li>- client #1 and client #2 left after his shift, which ended at midnight</li> <li>- he left the keys to the van in the office for former staff #2</li> <li>- stated he didn ' t leave until former Staff #2 arrived</li> </ul>	V 296		

Division of Health Service Regulation

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V 296	<p>Continued From page 7</p> <ul style="list-style-type: none"> <li>- after being informed other staff and clients reported former staff #2 arrived approximately 3 hours late, staff #3 maintained she (former staff #2) was there when he left at midnight.</li> <li>- see reference to "Employee Correction Plan" written for staff #3 leaving on 5-3-20/5-4-20 prior to former staff #2 arriving.</li> </ul> <p>Review on 9-17-20 of the "Successful Transitions Employee Corrective Action Plan" dated 5-4-20 and written by the QP on staff #3 revealed:</p> <ul style="list-style-type: none"> <li>- Type of Infraction: <ul style="list-style-type: none"> <li>- "Violation of Company Policy"</li> <li>- "Violation of Safety Rule"</li> <li>- "Negligence"</li> </ul> </li> <li>- Description of Incident: <ul style="list-style-type: none"> <li>- "...at the end of consumer shift, staff left his shift on time but didn ' t inform his supervisor that no one had arrived to relief him causing the consumers to be unattended for over an hour and a half;"</li> <li>- "...two consumers went AWOL from the consumers window and stole the consumer ' s van due to staff tardiness and failure to inform anyone of his tardiness."</li> <li>- "This is a direct violation of company policy (Leaving a consumer unattended by staff in the facility to include only one staff in the facility alone with consumer ... leaving keys out where they are accessible to the consumers and/or strangers ...all keys should be on the staff at the London) and grounds for terminations under the NC Health Registry Act for neglect of a child"</li> <li>- "Immediate Correction is required ..."</li> <li>- Employee ' s Comments: <ul style="list-style-type: none"> <li>- "Im aware of the consequences of my actions for I did not follow the correct procedures in handling the situation before me."</li> </ul> </li> <li>- signed by staff #3 on 5-5-20</li> </ul> </li> </ul>	V 296		



Division of Health Service Regulation

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V 296	<p>Continued From page 8</p> <p>Interview on 9-11-20 with the QP revealed:</p> <ul style="list-style-type: none"> <li>- "[client #1] and [client #2] said they took the keys to the office from Mr. [staff #1] while he was asleep on the couch in the living room."</li> <li>- "Then they went to the office and got the van keys."</li> <li>- "To be honest, I didn ' t know the van was stolen and they had not gone on foot until the next morning. The van had just gotten back from being serviced and wasn ' t parked where we normally leave it."</li> <li>- "So when they ran out of gas in [a town more than 60 miles away], [client #2] ' s father picked them up"</li> <li>- the Licensee/Co-Director (LCD) picked up both clients from client #2's father ' s residence</li> <li>- the policy has always been to not leave until your replacement arrives</li> <li>- staff have been retrained on these procedures</li> <li>- "second, always give the keys to a staff that ' s awake."</li> </ul> <p>Interview on 9-11-20, 9-17-20 and 9-18-20 with the LCD revealed:</p> <ul style="list-style-type: none"> <li>- " ...we don ' t really know when they got the keys."</li> <li>- "Then when the shift changed, 3rd shift, Ms. [former staff #2] was late due to car trouble, so for about 15 minutes there was only one staff there."</li> <li>- "[staff #1] was out of the office cleaning"</li> <li>- "the kids were in their beds. [Staff #1] had already done his bed checks."</li> <li>- "[former staff #2] was supposed to call the group home, then [QP], then me if they can ' t get anybody. But she didn ' t. Ms. [QP] did a</li> </ul>	V 296		

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V 296	<p>Continued From page 9</p> <p>disciplinary action of not following the protocol on [staff #3] and Ms. [former staff #2]."</p> <ul style="list-style-type: none"> <li>- "We pressed charges for them stealing the car."</li> <li>- "They ran out of gas in [a town more than 60 miles away]."</li> <li>- "I don ' t think it ' s right for us to be penalized because staff have emergencies. We should be given some considerations because we always have at least two staff scheduled. There are some providers in this business that don ' t even do that. Sometimes staff have emergencies and have to call out. I don ' t think it ' s right. There should be some leeway if staff have to leave at the end of their shift and go on to another job or if they have a sick child and have to leave. I think [previous Facility Compliance Consultant] once said there was a grace period of 20 minutes or so, that if there was only one staff, that it was alright." <p>Review of an email from the LCD on 9-17-20 revealed:</p> <ul style="list-style-type: none"> <li>- "I remember being told we were allotted 20 minutes in emergency situations. I understand this does not apply to this situation because this was clearly a violation of our policy and it was addressed as you can see. I don't think this is realistic because I can't predict emergencies in this industry. We strive to stay in ratio at all times and it is not realistic to have three staff for the amount they pay. Nonetheless, as you can see the situation was documented and all staff will be retrained."</li> <li>- "...I've been in this field for a while and have gone through a lot of growing pains. Yet this is not realistic. I just want this on record."</li> <li>- "Nonetheless, we will do our best to enforce this and minimize these occurrences from</li> </ul> </li></ul>	V 296		

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V 296	<p>Continued From page 10</p> <p>happening. I guess this is why we pay attorneys the big bucks to litigate matters like this when we do everything realistically possible to avoid these situations."</p> <p>Review on 9-18-20 of a Plan of Protection written 9-17-20 and 9-18-20 by the LCD revealed:</p> <p>What immediate action will the facility take to ensure the safety of the consumers in your care?</p> <p>"The QP will document this coaching and review with each staff prior to them starting of their shift, starting today, 9/17/20, and before every staff reports to work to include the weekend staff.</p> <p>A coaching will be done immediately to inform the staff of immediate termination and up to reporting the staff to the Healthcare Registry for neglect if a client is left improperly supervised and an incident occurs endangering the safety of the client and/or others involved due to lack of supervision. Staff will be informed they are not to leave the shift until their immediate supervisor or another staff member reports within 30 minutes and/or the agreed time between the supervisor and the staff needing to be relieved.</p> <p>The QP will personally review this with every staff to ensure adequate coverage is being provided at all times."</p> <p>Describe your plans to make sure the above happens.</p> <p>"The QP will document this coaching and review with each staff prior to them starting of their shift, starting today, 9/17/20. The QP will scan in all coaching that have been signed by the staff and</p>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mh1041-818</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/18/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SUCCESSFUL TRANSITIONS, LLC RESIDENTIAL CAF</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1458 LONDON DRIVE HIGH POINT, NC 27262</b>
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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 296	<p>Continued From page 11</p> <p>the QP by Monday, 9/20/20 and no later than 4:00pm. Each coaching will be filed in the staff ' s folder. She understands the QP or the designated staff has 30 minutes to arrive to the facility to make sure the required staffing ratio is being met at all times. It will be reiterated in the staff ' s coaching they are NEVER to be with fewer than two (2) staff persons. The rule (.1704) states "A direct care staff shall be able to reach the facility within 30 minutes at all times"</p> <p>This deficiency was cited two times in the previous year on 2-8-19 and again on 10-4-19.</p> <p>This facility is licensed to provide residential treatment to children and adolescents with serious mental health diagnoses such as Conduct Disorder, Post Traumatic Stress Disorder, Mood Disorders and Oppositional/Defiant Disorder, thereby requiring a minimum of two staff to be present at all times. The safety and well-being of the client's was not ensured due to inadequate staffing and supervision. Two 14 year old boys (clients #1 and 2) were not provided appropriate staff supervision on 5-4-20. Staff #3 left work at midnight on 5-4-20 before FS #2 arrived for her shift. That left only 1 staff at the facility and he was asleep (staff #1). Client #1 and #2, left alone without staff supervision, were able to go into the staff office and take the facility van keys. They stole the facility van and drove over 60 miles in the middle of the night (some time after midnight) until they ran out of gas. Staff #1 was not aware the clients were missing until around 3:00am when he awakened. Staff did not know the clients had stolen the facility vehicle until later that morning when they received a call from client #2's father. This deficiency constitutes a Type A1 rule violation for serious neglect and must be</p>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mhl041-818</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/18/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SUCCESSFUL TRANSITIONS, LLC RESIDENTIAL CAF</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1458 LONDON DRIVE HIGH POINT, NC 27262</b>
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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 296	Continued From page 12  corrected within 23 days. An administrative penalty of \$1000.00 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 296		