STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mhl049-098	A. BUILDING: _____ B. WING _____	R-C 10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STICKNEY HOUSE	120 ROCKWELL LOOP MOORESVILLE, NC 28115

(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 and follow up survey was completed on 10/16/20. The complaint was substantiated (intake #NC00169155). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents A sister facility is identified in this report. The sister facility will be identified as sister facility A. Staff and/or clients will be identified using the letter of the facility and a numerical identifier.	V 000		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client.	V 132		

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V 132	Continued From page 1 e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to complete an investigation within 5 working days of the initial notification to the Department and failed to put measures in place to protect the clients during the investigation. The findings are: Review on 9/18/20 of the Incident Response Improvement System (IRIS) revealed: - There were no internal investigations submitted to IRIS for the 8/15/20, 8/20/20, or 9/2/20 incidents that pertained to allegations against former staff (FS) #9 (refer to V512 for the specifics of the incidents). Interview on 10/9/20 with the Licensee revealed: - "[The Operation Manager (OM)] has the overall	V 132		

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V 132	Continued From page 2 decision about internal investigations being completed." Interview on 10/12/20 with the OM revealed: - She was not aware of any policy about how internal investigations should be done - "We are all figuring this (policy on how facility does internal investigations) out this week as this unfolds." Interview on 10/8/20 with the Qualified Professional (QP) revealed: - "I do not do internal investigations. [The Human Resource Manager] and [the OM] do the internal investigations." Review on 10/13/20 of FS #9's work schedule revealed: - She worked 8/15/20-8/26/20. - She also worked 8/29/20, 8/30/20, 9/1/20 and 9/2/20. - She continued to work following allegations of abuse and during an investigation. This deficiency is cross referenced into 10A NCAC 27D .0304 Protection from Harm, Abuse, Neglect or Exploitation (V512) for a Type A1 rule violation and must be corrected within 23 days.	V 132		
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.	V 293		

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V 293	Continued From page 3 (b) Staff secure means staff are required to be 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 4	V 293		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to provide continuous supervision and failed to coordinate care affecting 1 of 2 former clients (FC #3). The findings are

Review on 10/2/20 of FC #3's record revealed:
- Admission Date: 5/18/20
- Discharge Date: 9/2/20
- Diagnoses: Attention-deficit hyperactivity Disorder, Combined Type; and Disruptive Mood Dysregulation Disorder
- Age: 12 years-old
- Review of FC #3's admission assessment dated 4/15/20 revealed:
- "Trauma History: Dad took custody at 9 years old. 4th of July [FC #3] was defiant dad no longer wanted him, acted out, severe abandonment issues. Witness to domestic violence, abused. Mom- Substance abuse issues (stole meds); no contact with dad ..."
- "Suicidal Ideation/intent/attempts: None"
- "Homicidal Ideation/intent/attempts: None"
- "Risk Factors (Past & Current): Aggression (Physical/Verbal/Sexual): Physical, yes; hits things or people when he gets mad-feels better now and is working on it."
- Review of FC #3's discharge summary dated 9/2/20 revealed: "During his Level 3 placement, [FC #3] has encountered challenges with emotional regulation, property destruction, verbal/physical aggression and impulsivity. [FC #3] presents in a generally pleasant manner until he is provoked by his peers. [FC #3] becomes

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V 293	Continued From page 5	V 293		

angry, participates in AWOL (absent without leave) behaviors, and is uncooperative, expressing severe emotional breakdowns and aggression, especially when he feels blamed. [FC #3] is willing to process with staff once he has calmed down..."

Review on 9/23/20 of former client (FC) #3's hospital record revealed:
- Arrival Date/Time: 9/2/20 18:41 (6:41 pm)
- "20:00 (8:00 pm): Unable to get ahold of [the group home] in regards, to the patient (FC #3). The patient was brought in by EMS (Emergency Medical Services) without any paperwork from [the group home], phone numbers, or emergency contact information. Pt (Patient) keeps asking if we can get someone from [the group home] here, pt has been reassured that we have called them several times with no answer."
- "21:00 (9:00 pm): We have still not received a call back from [the group home]. We have left several voice mails. The sheriff's office has been contacted at this time to go to the residence to help get someone from [the group home] to the ED (emergency department)."
- "21:15 (9:15 pm): Received a call back from [the group home], they stated that they were supposed to send a binder with his information and a representative from [the group home], we assured them that neither of that happened. They stated they will send someone to the ER (emergency room) ASAP (as soon as possible) with appropriate necessary health record."

Interview on 9/24/20 with the Associate Professional (AP) revealed:
- On 9/2/20, she went to the group home to pick up FC #3's medical book to take to the hospital. The sheriff deputy had arrived at the group home and stated the hospital had called and said no

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V 293	Continued From page 6 staff were at the hospital. She told the sheriff deputy she was on her way. - Her first text sent to the Quality Assurance/Quality Improvement (QA/QI #1) from the hospital, was sent at 9:05 pm to let the QA/QI #1 know she had arrived at the hospital. - The hospital staff told her they had been calling for 2 hours. She learned the phone number the hospital staff called was from their website which was their office phone and because it was after hours no staff were in the office. - "Our new protocol should be the office phone calls should roll over to the on-call staff."	V 293		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident;	V 367		

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V 367	Continued From page 7 (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided	V 367		

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V 367	Continued From page 8 by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to report all Level II incidents that occurred during the provision of billable services to the LME (Local Management Entity) within 72 hours of becoming aware of the incident. The findings are: Review on 9/18/20 of the Incident Response Improvement System (IRIS) revealed: - There was no incident report in IRIS for the 8/20/20 incident that pertained to allegations against former staff (FS) #9. Interviews on 10/2/20 and 10/13/20 with the QP	V 367		

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V 367	Continued From page 9 revealed: - On 8/15/20, she talked to FS #9 about the incident with FC #2. She asked FS #9 if she was ok and asked if she needed to go to the hospital. FS #9 told her she did not need medical attention. She also asked FS #9 if she wanted to work at one of their other group homes. - When she did the IRIS report for the 8/15/20 incident, she only knew: FC #2 punched FS #9, then FC #2 ran outside yelling and screaming and attempted to rip the electric box off the side of the house. She also knew that staff A1 from the sister facility A had come over to calm down FC #2. - She talked to FC #2 by phone sometime on 8/15/20 or 8/16/20 in response to the 8/15/20 incident. She asked FC #2 if he was ok. FC #2 did not tell her at that point he had been pushed. - When she talked to FC #2 on 8/17/20, FC #2 told her that FS #2 pushed him. She never asked FC #2 if he had sustained any injuries on 8/15/20. - She learned from the OM and the Human Resource Manager later in the week of 8/17/20, that FS #9 admitted to them she had put hands on FC #2 "in self-defense." - She did not update the IRIS report to include the part about FS #9 pushed FC #2 because she did not know she was supposed to do that. - The Quality Assurance/Quality Improvement (QA/QI #1) and the Operation Manager (OM) never told her that FS #9 encouraged clients to fight on 8/20/20 so she would not have completed an IRIS report about the incident. - FS#9 was not removed from the work schedule until 9/2/20. - "I was following orders from [the OM] about IRIS reports." - "I have learned more in the two days from you about IRIS reporting."	V 367		

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V 367	Continued From page 10 Interview on 10/7/20 with the OM revealed: - She had text with the QA/QI #1 when the 8/20/20 incident occurred. In the text she had been told FS #9 had "the boys play fight each other." - She did not know why the QP did not know about the 8/20/20 incident. - She supervised the QP. This deficiency constitutes a re-cited deficiency. This deficiency is cross referenced into 10A NCAC 27D .0304 Protection from Harm, Abuse, Neglect or Exploitation (V512) for a Type A1 rule violation and must be corrected within 23 days.	V 367		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter.	V 512		

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V 512	Continued From page 11 (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on record reviews, and interviews, 1 of 1 former staff (FS #9) abused 2 of 7 former clients (FC #2 and #3), neglected 1 of 1 current client (client #1) and 2 of 7 former clients (FC #2 and #3); the Operations Manager (OM) and the Qualified Professional (QP) failed to protect 1 of 1 current client (client #1) and 2 of 7 former clients (FC #2 and #3) from abuse and neglect. The findings are: Cross Reference: G.S. 131E -256 HCPR Prior Employment Verification (V132) Based on record reviews and interviews, the facility failed to complete an investigation within 5 working days of the initial notification to the Department and failed to put measures in place to protect the clients during the investigation. Cross Reference: 10A NCAC 27G .0604 Incident Reporting Requirements (V367) Based on interview and record review, the facility failed to report all Level II incidents that occurred during the provision of billable services to the LME (Local Management Entity) within 72 hours of becoming aware of the incident. Review on 10/5/20 of FS #9's record revealed: - Hire Date: 7/2/20 - Last Date of Employment: 9/2/20 - Position: Paraprofessional - Based on review of the record, FS #9 has a degree and work history that qualifies her as a Paraprofessional.	V 512		

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V 512	Continued From page 12 Review on 10/16/20 of the QP's record revealed: - Hire Date: 2/12/18 - Position: Qualified Professional - Based on review of the record, the QP has a degree and work history that qualifies her as a Qualified Professional. Review on 10/15/20 of the OM's record revealed: - Hire Date: 12/7/17 - Position: Operations Manager - Based on review of the record, the OM has a degree and work history that qualifies her as a Qualified Professional. Review on 10/2/20 of client #1's record revealed: - Admission Date: 5/21/20 - Diagnoses: Disruptive Mood Dysregulation Disorder; Attention-deficit hyperactivity Disorder, Combined Type; and Anxiety Disorder, Unspecified - Age: 12 - Review of client #1's admission assessment dated 5/12/20 revealed: - "Trauma History: Homeless (mom), mom abuses drugs, father left. Witness to abuse. " - "Risk Factors (Past & Current): Physical, yes hits things or people when he gets mad; if he is picked on he will go straight to physical aggression (says [client #1])." - Review of Client #1's goals in the PCP (Person Centered Profile) dated 8/26/20 revealed: - " ...will work on controlling his anger when he is mad. He will use his coping skills when he begins to feel angry. He will express his feelings effectively." - " ...will use effective communication when expressing his feelings." - " ...will participate in the RDC (Rockwell Development Center) program. He will follow the	V 512		

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rules and expectations set. He will follow daily chores, and tasks set by support staff."
- " ...will participate in therapy individual and group."
- " ...will learn independent living skills as well while at RDC."

Review on 10/2/20 of FC #2's record revealed
- Admission Date: 7/7/20
- Discharge Date: 9/16/20
- Diagnoses: Disruptive Mood Dysregulation Disorder; Generalized Anxiety Disorder and Attention-deficit hyperactivity Disorder, Combined Type
- Age: 16 years-old
- Review of FC #2's admission assessment dated 6/9/20 revealed:
- "Trauma History: Hasn't seen or spoken to parents since he was 10. Sister accused mom and dad of sexually abusing her. Sister passed away a few weeks ago."
- "Risk Factors (past and current): Physical, yes; hits things or people when he gets mad ..."
- Review of FC #2's Discharge Summary dated 9/16/20 revealed: "During his Level 3 placement, [FC #2] encountered challenges with emotional regulation, property destruction, verbal/physical aggression and impulsivity. [FC #2] presents in an angry, resentful, and generally uncooperative manner and expresses severe emotional breakdowns and aggression, especially when he is redirected. [FC #2] has been physically and verbally aggressive toward peers and staff and often expresses hostile defiance. On 8/22/20 the client required police contact due to physical aggression toward direct care staff and property destruction."

Review on 10/2/20 of FC #3's record revealed:
- Admission Date: 5/18/20

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V 512	Continued From page 14 - Discharge Date: 9/2/20 - Diagnoses: Attention-deficit hyperactivity Disorder, Combined Type; and Disruptive Mood Dysregulation Disorder - Age: 12 years-old - Review of FC #3's admission assessment dated 4/15/20 revealed: - "Trauma History: Dad took custody at 9 years old. 4th of July [FC #3] was defiant dad no longer wanted him, acted out, severe abandonment issues. Witness to domestic violence, abused. Mom- Substance abuse issues (stole meds); no contact with dad ..." - "Suicidal Ideation/intent/attempts: None" - "Homicidal Ideation/intent/attempts: None" - "Risk Factors (Past & Current): Aggression (Physical/Verbal/Sexual): Physical, yes; hits things or people when he gets mad-feels better now and is working on it." - Review of FC #3's discharge summary dated 9/2/20 revealed: "During his Level 3 placement, [FC #3] has encountered challenges with emotional regulation, property destruction, verbal/physical aggression and impulsivity. [FC #3] presents in a generally pleasant manner until he is provoked by his peers. [FC #3] becomes angry, participates in AWOL (absent without leave) behaviors, and is uncooperative, expressing severe emotional breakdowns and aggression, especially when he feels blamed. [FC #3] is willing to process with staff once he has calmed down..." Finding #1 Review on 9/18/20 of the Incident Response Improvement System (IRIS) revealed: - Date of Incident: 9/2/20 - Date Last Submitted: 9/4/20 - Name of Person completing this form: the QP	V 512		

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V 512	Continued From page 15 - "[FS #9] reported: (summarized the IR (Incident Report) that was turned in) Client (FC #3) put items in front of his door. Client was pounding head against wall. He was asked to stop. Client attempted to tie a shirt around his neck. He began to tear up his room. Attempted to go out is window. He was stopped by staff. He went AWOL (absent without leave). He did come back to the house. Reported by [Quality Assurance/Quality Improvement (QA/QI #1)]: (summarized from IR (incident report)) [QA/QI] received a face time from [FS #9] regarding the behavior of [FC #3]. [FC #3] was AOWL, but around the corner in the parking lot of the pub at the corner. She informed [FS #9] of proper protocol. [FS #9] called again and had the camera on [FC #3], he was in his room in what appeared to be a suicide attempt. [QA/QI #1] went to the group home. He (FC #3) was speaking to a police officer. [QA/QI #1] processed with [FC #3]. EMS (Emergency Medical Services) had spoken to [FC #3] and with his comments they determined he needed to go to the hospital to be checked out. [Therapist] the therapist was next door, and she was asked to come and talk to [FC #3] as well. [FC #3] was transported to [local hospital]." Interviews on 9/22/20 and 9/23/20 with staff #3 revealed: - She worked on 9/2/20 and was on shift at 3:30 pm. FS #9 had worked the shift before and worked a second shift with her. - FC #2, FC #3 and client #1 had just returned from an outing at a store where FS #9 bought FC #3 a toy car. - The clients had just finished quiet time in their room and FC #3 wanted to go back into his room. - FS #9 told FC #3, "[FC #3] what did I tell you, I told you if you go to your room right now you can't	V 512		

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come out until dinner."
- FC #3 went back into his bedroom and she heard "a loud thump" in FC #3's bedroom. She was in the living room area which is next to FC #3's bedroom. The thumping noises got louder so she and FS #9 went into FC #3's bedroom.
- FC #3 was in his closet banging his head. She told FC #3 to calm down, that everything was going to be ok and asked him to talk to her.
- FC #3 kept banging his head on the wall and said he was "sick of this place."
- She then saw FC #3 take a t-shirt and wrap it around his neck and his face turned red.
- While she attempted to calm down FC #3 she tripped over something on the floor and fell down. FC #3 then came out of his closet.
- FS #9 contacted the QA/QI #1 on facetime.
- FC #3 realized he was on facetime and became upset. FC #3 grabbed for FS #9's phone.
- Then FS #9 grabbed for FC #3's collar (he was wearing a t-shirt).
- She told FS #9 "to calm down" and told FC #3 "to calm down, it is ok."
- "[FS #9] reached for [FC #3] quickly by his collar and did it so quickly [FC #3] fell down on his bed and then the sheriff was in the bedroom. It caught me off guard (the sheriff deputy walking into the bedroom). I was trying to intervene and out of nowhere a sheriff deputy came into the bedroom. When the deputy sheriff came in [FC #3] was on his bed."
- "I saw whelps on his neck. I think I saw two or three whelps. If I were [FC #3] the whelps were on his right side. I told DSS (Department of Social Services) and my manager (Human Resource Manager and Operations Manager) the marks could have come from anywhere because everything happened so fast. The marks could have come from [FC #3] wrapping the t-shirt real tight around his neck until his face turned red and

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his eyes popped out."
- FC #3 was taken to the hospital by the EMS.
- She could not recall what FS #9's fingernails looked like that day.
- Felt that FC #3 initially became upset on 9/2/20 because FS #9 took his toy car away from him. She did not know why FS #9 took the toy car away.

Interviews and review on 9/22/20, 9/24/20, and 10/1/20 with the Associate Professional (AP) revealed:
- She was not in the group home when the 9/2/20 incident occurred but took FC #3's medical book to the hospital.
- When she arrived at the hospital and saw FC #3 she noticed scratches. She asked FC #3 if he was ok and he said he wanted to go home. She also observed a mark on his right eye. She took pictures of the injuries.
- She provided pictures of the injuries.
- On 9/22/20 at approximately 2:49 pm reviewed pictures taken by the AP of FC #3's face and neck when he was in the hospital on 9/2/20. FC #3 to have 4 red raised scratch marks to the right side of his neck.
- FC #3 told her that the injuries occurred on 9/2/20 when FS #9 recorded him on her phone and was not supposed to record him. FC #3 told her that he knocked the phone out of FS #9's hand. FC #3 further reported to her that FS #9 then grabbed him around his neck and pushed him onto the bed. FS #3 also told her that was when he felt he hit his eye.
- She asked FC #3 if he tried to hurt himself and FC #3 told her he put a t-shirt around his neck to try to pass out. He said he did this every night to go to sleep. She told FC #3 that was not true because she worked at the house a lot and always read him stories at bedtime, and he would

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go to sleep.
- She reported that FC #3 had never self-harmed and thought it was strange for him to talk about tying a t-shirt around his neck.
- "I knew it was scratch marks on [FC #3's] neck not from the t-shirt around his neck."
- I took pictures of his face and neck. You can tell it (the scratches) were from her (FS #9's) left hand and she was filming with her right hand.
- She contacted the OM and told her what happened.
- "[FS #9] had a full set of acrylics on that day (9/2/20). Her nails were about two inches long. [FS #9] always had her nails done. When I saw the scratches, I knew it was her who did it because she always has fingernails. I said to [the QA/QI #1] and other staff that if someone test under [FS #9's] fingernails you would see [FC #3's] DNA (Deoxyribonucleic acid)."

Interview on 10/1/20 with the QA/QI #1 revealed:
- On 9/2/20, she received a facetime call from FS #9 who indicated that FC #3 had gone AWOL. She could see that FS #9 was walking outside.
- FS #9 was able to get FC #3 back to the group home then FS #9 made a second facetime call to her.
- During the second facetime call, FS #9 showed her FC #3's bedroom and it was "a disaster." FC #3 was in his closet and he was trying to put some type of cloth around his neck. FC #3 was screaming and crying. He said he wanted to kill himself. FC #3 does not have a history of suicidal behaviors. She decided to drive over to the group home.
- When she arrived at the group home the sheriff deputy was talking to FC #3 on the front porch. FC #3 never told the sheriff deputy anything that FS #9 did to him. She felt FC #3 might have been too fearful to say anything about FS #9 because

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V 512	Continued From page 19 FS #9 was present. - She saw red marks on his neck and a mark under his eye but could not recall which side of his neck or which eye had the mark. - FC #3 was taken to the hospital. The AP later went to the hospital and she talked to FC #3 by facetime while he was at the hospital. - When she talked to FC #3 by facetime, he said he did not want to get FS #9 in trouble. That's when she realized something was not right with the story about how he got the marks on his neck. - While in the hospital, FC #3 shared with the AP what FS #9 did to him - "From what I was informed the marks on his neck were from [FS #9] yanking him up and threw him on the bed and that would explain why the (FC #3's) bed was not in the normal place in the room." Review on 10/2/20 of the Sheriff Department record revealed: - "Date/Time Received: 9/2/20 17:35:22 (5:35 pm)" - "Arrived on scene at 120 Rockwell Loop at the Rockwell Development Center. As I approached the home I could see [FC #3] attempting to get away from staff and trying to open the window so that he could run away. [FC #3] was being very loud and shouting that he wanted to leave and did not want to stay there anymore because they treated him badly. As I entered the home, I went to the bedroom and asked the staff to back away from him. I then took [FC #3] by the right arm and calmly asked him to walk with me so that we could talk. [FC #3] complied and walked with me to the front porch. After a few moments, [FC #3] was able to calm down and let me know what was going on. [FC #3] said that he went for a walk at that time [local street] to try to cool down. As he returned to the house, [FC #3] said that he	V 512		

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became upset again and began getting loud with the staff. [FC #3] told me that during that time he placed a shirt around his neck in an attempt to pass out so that he did not have to deal with it any longer. I noticed that he had some minor abrasions on his neck where the shirt had rubbed it raw. I then talked to the staff as I was waiting for EMS to arrive. They told me that he had made some comments about trying to hurt himself. I then asked [FC #3] and he told me that he did not really mean to hurt himself and that he did not want to kill himself. [FC #3] told me that he just did not want to stay at the [group home] any longer. EMS then arrived on scene and transported [FC #3] to [local hospital] ..."

Interview on 10/7/20 with the Sheriff Deputy revealed:
- When he arrived at the group home on 9/2/20, FC #3 was yelling and screaming and would not let staff members near him.
- When he walked into FC #3's bedroom the staff members stepped back.
- He held onto FC #3's wrist and walked him out to the front porch.
- FC #3 was a different person outside the group home. He talked to FC #3 on the front porch and he "was cooperative."
- One of the staff (unknown which staff member) walked out onto the front porch and that seemed to agitate FC #3.
- He observed scratches on FC #3's neck and on the same side as the scratches, there was a mark on his eye.
- FC #3 told him the marks were self-inflicted from when he wrapped a t-shirt around his neck.
- FC #3 reported he became agitated when a staff member took a toy away from him for a rule violation.
- FC #3 was taken to the hospital that evening by

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V 512	Continued From page 21 EMS. - "[FC #3] indicated he did not want to kill himself and that he was just trying to get out of the home." - "Every time we go out to one of their group homes, it feels like the staff are inadequate." Review on 9/23/20 of FC #3's hospital record revealed: - Arrival Date/Time: 9/2/20 18:41 (6:41 pm) - "Presenting complaint: EMS states: tied a shirt around his neck has abrasions to right side of neck ..." - "12-year-old male comes in with self-inflicted choking injury. I filled out IVC (Involuntary Commitment) papers. After he had been here for few hours he told me that the wounds on his neck came from the caregiver at the group home. He said she was video taping him and he took her phone and then she grabbed him by the neck and slammed him onto the bed." Interviews on 9/30/20 and 10/6/20 with FC #3 revealed: - On 9/2/20, he had left the house and walked around the block "to blow off some steam." He was upset because FS #9 was upset with him for buying a drink with caffeine. - When he returned FS #9 tried to make him go back into his bedroom after he had gotten out of his bedroom. He was being "punished" by FS #9 for buying the caffeinated soda. - He "tore up" his bedroom. - FS #9 started recording him on her cell phone. - He took FS #9's cell phone away from her and she "tried to strangle" him. FS #9 put marks on his neck. - As FS #9 tried to strangle him "with both hands" she threw him down on the bed. - He was facing FS #9, as he fell back onto his	V 512		

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bed. He turned his head to the right to see where he was falling.
- His face hit the springs on the bed.
- Law enforcement came into the bedroom and pulled FS #9 off of him. Law enforcement took him by the hand and talked to him outside.
- The EMS came to the group home and took him to the hospital.
- Denied that he put a t-shirt or hanger around his neck. He did put a t-shirt around his chest because the soft t-shirt calmed him down.
- Staff #3 was in the bedroom and did not do anything, she just watched.
- "There were marks on the right side (of my neck) there were a few and on the left side."
- "Oh no that's a lie I did not try to strangle myself."
- "[FS #9] did (grab my neck)."
- "I think [FS #9] should be arrested and put in jail for child abuse when she tried to strangle me."

Interview on 9/18/20 with client #1 revealed:
- On 9/2/20, he, FC #2, FC #3, the Associate Professional (AP) and FS #9 had returned from a local store. While at the store FS #9 bought FC #3 a toy car.
- While at the store FC #3 had purchased a drink with caffeine and FC #3 was not supposed to have caffeine.
- FS #9 made FC #3 go to his bedroom "for not listening" and buying a caffeinated drink.
- He was in the group home when FS #9 told FC #3 "you can get your toy car back when you deserve it." FC #3 got mad and left the group home but soon returned.
- When FC #3 returned to the group home, FC #3 went into his room and "cracked his neck, he turned it to the side and popped it and he tried to choke himself with a t-shirt."
- He saw FC #3 try to jump out of the window.

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- He was in the living room and only saw some of what occurred.
- He never saw marks on FC #3 but did see FC #3 scratch his face.
- Denied that he saw FS #9 ever put her hands-on FC #3.

Interview on 9/30/20 with FC #2 revealed:
- He had been gone for most of the day on 9/2/20 and when he came back FC #3 was playing.
- FC #3 told FS #9 he was tired and wanted to go to his bedroom. FS #9 told FC #3 there would be consequences if he came out of his bedroom that night. FC #3 often took naps and then would not sleep at night.
- FC #3 started yelling and cussing. He went outside and walked down the street, went AWOL and later returned.
- FS #9 had purchased him a toy car earlier that day and when he returned to the group home, FS #9 took the toy car away from FC #3 and that upset him.
- He was in the doorway of FC #3's bedroom.
- FC #3 was in his bedroom and "tried to choke himself" by putting a hanger around his neck. FS #9 tried to restrain him to stop him from choking himself. She was unable to restrain FC #3 because FC #3 pushed and punched at her. FS #9 started recording FC #3 with her phone.
- There was a second staff present, staff #3, who also tried to talk to FC #3 and calm him down. FC #3 pushed staff #3 and stepped on her hand. FC #3 pulled the closet door off the hinges. Then FC #3 started pushing his mattress off the bed and knocked his lamp off the dresser.
- He was unsure if FC #3 tried to grab FS #9's phone.
- He never saw FS #9 grab at FC #3's neck.
- He never saw marks on FC #3's neck. FS #9 and staff #3 took the hanger off FC 3's neck and

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did not scratch his neck.
- Law enforcement came into the bedroom and took FC #3 outside to talk to him.
- The ambulance arrived and took FC #3 to the hospital.
- "[FS #9] has long fingernails. She had her nails done."

Review on 10/14/20 of the Child Protective Services record dated 9/3/20 and 10/12/20 revealed:
- 9/3/20 Case Initiation with FC #3: "EDSW (Emergency Duty Social Worker) asked [FC #3] to tell EDSW what happened at the group home, prior to him being brought to [local mental health hospital]. [FC #3] reports it all started because a kid was mad because he could not do whatever he wanted, so he was given permission to steal my stuff. [FC #3] did not specify what stuff was taken or gave permission. [FC #3] admits he completely destroyed the room. [FC #3] reports he did take his shirt off and wring it, then wrapped it around his neck so it could rest on his chest. [FC #3] denies he was trying to kill himself. [FC #3] states [staff #3] removed the shirt. Once she removed it, [FC #3] states he tried to escape out the door, but he could not, so he then went to the window and tried to climb out."
- "[FC #3] states he realized [FS #9] had her phone out. [FC #3] states he took the phone from her and threw it on his bed. [FS #9] then grabbed him by the neck, causing the scratches to his neck. [FS #9] also caught in the right eye. [FC #3] states [FS #9] used both hands to strangle him. EDSW asked [FC #3] where [staff #3] was during the altercation. [FC #3] states [staff #3] stood back, but he could hear her telling [FS #9] to stop. [FC #3] reports someone called LE (law enforcement) and it finally ended. [FC #3] told EDSW, [FS #9] also punched him in the arm (left)

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causing it to bruise. EDSW asked when [FS #9] punched him during the altercation. [FC #3] reports it must have been after she strangled him."
- 10/12/20 Case Decision: "Neglect" was Substantiated- "Improper Discipline with Injuries"

Interviews on 9/30/20 and 10/1/20 with FS #9 revealed:
- She had worked in the group home for less than 3 months and had no prior experience.
- On 9/2/20, she, the AP, client #1 and FC #3 had returned from a store. She had bought FC #3 a toy car. At some point she took FC #3's toy car from client #1 and did not give it back to FC #3. While at the store FC #3 bought a soda and she had told him not to get a soda. She denied FC #3 had any consequences for buying a soda.
- When they returned to the group home, FC #3 went AWOL and was gone for "maybe 5 minutes." She contacted the QA/QI #1 when he went AWOL and followed him. She did not know why FC #3 went AWOL.
- When he came back to the group home he wanted to go to his bedroom, and she told him if he went to his bedroom, he would have to stay there the rest of the day. She had concerns if he went to his bedroom that he would go to sleep and be up at night.
- FC #3 went into his bedroom and started throwing items and screaming. He tried to snap his neck. He then went into his closet and tried to choke himself with a t-shirt. Staff #3 and FC #3 were in the closet and had a "tussle" as staff #3 tried to get the t-shirt from around FC #3's neck. FC #3 and Staff #3 fell in the closet.
- FC #3 came out of the closet and flipped his mattress and tore down the curtains.
- FC #3 got in her face and told her to get out of his bedroom.

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V 512	Continued From page 26 - She told him to back up and "pushed him back" when he came at her. Then they both fell onto the box spring. - FC #3 was on his back and she was on top of him on the box spring. One of her knees was on the box spring and she held FC #3 down with her left hand while she held her cell phone in her right hand. The QA/QI #1 was on facetime with her. Law enforcement arrived then EMS arrived and took him to the hospital. - "I held him down by his collar bone while we were on the bed and I told him to calm down. I got up when he calmed down and then the cop came in. The police (sheriff deputy) got him off the bed and took [FC #3] outside." - "I don't know anything about the scratches. I don't have any nails." Review on 10/1/20 of the "Employee Corrective Action Plan" dated 9/3/20 revealed: - Employee: [FS #9] - Signed by: The OM, the Human Resources Manager, and the AP - "Suspension/Leave Pending Investigation" - "There has been a claim made against employee indicating that the employee physically/aggressively put her hands a client (FC #3) ..." - No documentation that FS #9 was taken off the schedule while the investigation was occurring Review on 10/1/20 of the "Grievance Form" dated 9/3/20 revealed: - "Consumer's Full Name: [FC #3]" - "Consumer/Staff/Other person who grieved you: [FS #9]" - "Staff members signature: [the AP]" - "The issues are: Client [FC #3] stated to staff [the AP] that staff [FS #9] was recording him on her cell phone during a behavior and she isn't	V 512		

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supposed to do that. He knocked her phone out of her hand and she grabbed him around his throat and threw him on his bed. She scratched his neck and he hit his eye." Note: It was later found out that FS #9 was using facetime and not recording FC #3.
- "The facts supporting this are: [FC #3] has several scratches on his neck that look like fingernail marks. He has a bruise on his right eye."
- "The relief I want is: Her to no longer work there for everyone in management to know."
- "Other witnessed: [The QA/QI #1] and Doctor-made statements to; [Staff #3]-present for incident."

Finding #2

Interview on 10/1/20 with the QA/QI #1 revealed:
- On 8/20/20 she worked with FS #9.
- She was in the staff office on 8/20/20 and on the same hall FS #9 was in a vacant bedroom with client #1, FC #2, and FC #3.
- She heard the clients "play fighting."
- She opened the office door and noticed that FC #3 and FC #2 were "play fighting." FC #3 and FC #2 stopped when they saw her and she heard the clients comment, "the drill sergeant was coming."
- She text the OM about what had occurred.
- None of the clients who were play fighting were hurt.
- "[FS #9] was trying to teach them how to fight. I heard [FS #9] say, '[FC #3] don't back down.'"

Interview on 10/7/20 with the OM revealed:
- She received a facetime call from the QA/QI #1 on 8/20/20 around 8:00 pm.
- She could not see anything and could only hear the QA/QI's voice.
- The QA/QI #1 called to let her know that FS #9

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was allowing FC #2 and FC #3 to "play fight."

Review on 10/2/20 of text messages between the QA/QI #1 and the OM revealed:
- QA/QI #1: "She really got these kids in here on 1,000 horse playing. I'm documenting for this eval.(evaluation)."
- OM: "What's going on"
- QA/QI #1: "ft (facetime) me and put me on mute."
- OM: "Who is that"
- QA/QI #1: "[FS #9]"
- QA/QI #1: "you see???"
- OM: "What you ask her lol (laugh out loud)"
- QA/QI #1: "What are yall doing"
- QA/QI #1: "im going call. Just listen."
- OM: "Pull her to the side and say [FS #9] this typically leads to a crisis."
- QA/QI #1: "I am definitely. I know what to do lol I just wanted you to actually see what I see before I redirect it."
- OM: "I could hear them."
- QA/QI #1: "it dnt even make logical sense to have the boys play fight each other but I got the rest handled lol just making sure I had a creditable witness."
- OM: "I gotcha"

Review on 10/16/20 of "Pop-In on Shift Staff Report" revealed:
- Date: 8/20/20
- House: Stickney
- Shift: 2nd
- Staff: FS #9 and QA/QI #1
- Clients: Client #1, FC #2, and FC #3
- " ...before bedtime all the clients and even staff member (FS #9) was in the TV room. From the room I heard sounds similar to two clients were horseplaying as staff rooted them on. Staff should have been aware that this could possibly cause a

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crisis after [FC #3's] slight meltdown. I called [the OM] to witness, but she only heard and did not see. Once I redirected clients and staff all was well, although they referred to me as a drill sgt. (sergeant) Staff has struggles in choice making and professionalism, correct commentary/word choice but it is a possibly that she has hope with a conversation from upper management or training."

Interview on 10/6/20 with FC #3 revealed:
- FS #9 had encouraged him to fight client #1 and FC #2 was there. This occurred sometime during the summer of 2020.
- FS #9 told client #1 that he had said client #1 "was stupid."
- FS #9 said to client #1 "hit him (FC #3)." Client #1 attempted to hit him but missed and he tried to hit client #1 back.
- FC #2 told client #1 and FC #3 not to fight.
- He and client #1 hit each other on their arms.
- Neither client was injured or had marks.
- The QA/QI #1 walked outside to where the clients and FS #9 were located. The QA/QI #1 told the clients to stop fighting and told FS #9 to stop as well.

Interview on 10/7/20 with FC #2 revealed:
- He denied that FS #9 tried to get him or other clients to wrestle or play fight.
- He did not recall a time when the QA/QI #1 stopped clients from wrestling or fighting.

Interview on 10/12/20 with client #1 revealed:
- He denied that FS #9 tried to get him or other clients to wrestle or play fight.

Interview on 10/9/20 with FS #9 revealed:
- Denied that she ever encouraged clients to fight.
- "They are boys they play fight all the time. How

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do you stop kids from horse playing they do that all day."

Review on 10/13/20 of the Employee Corrective Action Plan dated 8/21/20 revealed:
- Action Taken: Counseling Statement
- Written by: The QA/QI #1
- "During the second shift on 8/20/20 everything ran as normal until fifteen or so minutes before bedtimes. As I began cleaning the office area,and completing roper documentations. As appeared I heard a lot of playing in the other room. [FS #9] was allowing the boys to horseplay with each other. I reached out and informed [the OM] of the current state situation at hand. I informed staff on shift, [FS #9] at what can result from this ...She was informed on what not to do during client interaction, as well as allowing the clients to horseplay."
- Further review revealed no documentation that FS#9 was removed from work the day of the incident.

Interview on 10/2/20 with the QP revealed:
- She did not know about the 8/20/20 incident where FS #9 encouraged clients to fight.

Review on 9/18/20 of the Incident Response Improvement System (IRIS) revealed:
- There was no incident report in IRIS for the 8/20/20 incident that pertained to allegations against FS #9.

Finding #3

Review on 10/13/20 of the Sheriff Department report revealed:
- Date/Time reported: 8/15/20 17:05 pm (5:05 pm)
- Location of Incident: 122 Rockwell Loop,

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V 512	Continued From page 31 Mooresville, NC 28115 - "I made contact with one of the staff members [FS #9], who stated the juvenile involved was [FC #2] who goes by [FC #2's other name] and was not sitting on the side of the residence. - [FS #9] said around 1700 hours (5:00 pm) they were giving [FC #2] his medication, he takes two different pills. [FC #2] started arguing that he was supposed to take one at 1700 and one at 2000 hours (8:00 pm). [FS #9] said they go by a form called the Medical Administrative Record, which stated both were to be given at 1700 hours. - [FS #9] stated they (FS #9 & FC #2) both started arguing back and forth, they started in the office then went into the living room. [FS #9] said [FC #2] started destroying the house, ripping down posters, throwing planters and any food or drinks that were out. [FS #9] said [FC #2] went back to the office and shut the door behind him, trying to use the phone. [FS #9] said [staff #2] who is another staff member, who had been present the whole time, pushed through door. - [FS #9] told me, while [FC #2] was trying to dial phone, she [FS #9] grabbed the receiver. [FC #2] then went back into the living room said he was going to hit [FS #9] with one of the boards off the wall. [FS #9] said she was on the phone facetiming [QA/QI #1]. While on the phone, [FC #2] shoved [FS #9], so she shoved him back. - [FS #9] said they were fighting back and forth, where at some point she was hit in the lip. [FS #9] said they ended up by the front door, where it stopped. [FC #2] went outside and [FS #9] retrieved her phone, then went outside to wait for law enforcement ... - I then made contact with [FC #2] and asked him to tell me what happened. [FC #2] said that the staff were giving him his medication, stating he was to take both at 1700 hours. [FC #2] told me just last Thursday he went to the doctor's office	V 512		

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for a medication management appointment.
- [FC #2] said the doctor changed the time to 2000 hours because the medication made him drowsy. He stated that he saw on the staff form that someone had crossed out the 2000 hours and wrote in 1700 hours. [FC #2] said he and [FS #9] started yelling and he tried calling his case worker.
- He told me they would not let him call her, so he started slamming the phone down, then went into the living room and started pulling everything off the walls and throwing whatever he could find. [FC #2] said he did threaten to hit [FS #9].
- [FC #2] said he then blacked out and could not tell me what else happened. I asked him to try to remember, all he could tell me was he went outside, threw the school chair off the patio, and knocked down the basketball hoop. [FC #2] told me he did not damage the electrical box, he just opened the door to it ..."

Review on 9/18/20 of the Incident Response Improvement System (IRIS) revealed:
- Date of Incident: 8/15/20
- Date Last Submitted: 8/19/20
- Name of Person completing this form: the QP
- "As reported by support staff on shift [FS #9]" [FC #2] refused his 5 pm medication. [FS #9] discussed with him what staff needed to follow regarding medications. He began to demand staff to call the doctor and was upset when staff could not. He began to throw things around the house, cups, and knock things off the wall. This caused holes to be put in the wall. He made aggressive moves toward staff. Punched staff in the face. Walked out of the house attempted to take the fuse/electric box off the side of the house. The police were called, and a report for property damage was completed. [FS #9] who was hit by him, also pressed charges. None

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V 512	Continued From page 33 (charges) have been officially made." Interview on 10/7/20 with FC #2 revealed: - Prior to 8/16/20, he had been to the doctor and had reported a medication he took at 5:00 pm made him sleepy. The doctor told him to take it "at night." He could not remember the name of the medication. - On or around 8/16/20, he refused to take his 5:00 pm medication and wanted to take it at night. He could not recall which clients were present but indicated staff #2 also worked that day. - FS #9 tried to make him take the medication at 5:00 pm. - FS #9 told him "I am not going to feed into your lies" and he got upset. - He and FS #9 got into "a pushing battle." He pushed first. He was unsure how many times FS #9 pushed him, but it was more than one time. The pushing occurred inside the group home. - He went outside and slammed the basketball goal down and punched the electric box on the side of the house. - An unknown staff from the group home next door came over and talked to him. The unknown staff calmed him down. Then the police came. - "[FS #9] pushed me in my face and stuff. She actually scratched me to where I was bleeding on my face." He was not provided any first aid for the scratches on his face. Interview on 10/9/20 with FS #9 revealed: - On 8/15/20, FC #2 told her that the doctor changed the time "a medicine that he took to keep him calm" from 4:00 pm to 8:00 pm. She could not recall the name of the medication. - She was not sure if the doctor changed the time the medicine was to be given. - After the incident she did see that the time the medication was to be given was changed to 8:00	V 512		

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pm.
- When FC #2 refused to take the medication, he flipped out.
- FC #2 went through the house and threw stuff and took the writing board off the wall and said he was going to hit her. She contacted the QA/QI #1 on facetime. Staff #2 who had been in the staff office came into the living room beside the kitchen where she and FC #2 were located. FC #2 threw staff #2's drink on the floor.
- Client #1 and FC #3 were in a vacant bedroom watching TV when the incident occurred. The clients peeked out and might have seen some of the incident.
- FC #2 started getting in her face and pushed her. He pushed with his full body and poked his chest out.
- She dropped the phone and pushed FC #2 off her. They pushed each other several times and then he ran outside. He flipped the basketball goal down, threw the desk that was on the front porch down, and went over to the electric meter box on the side of the house.
- Staff A1 from the sister facility A next door came outside and calmed FC #2 down. Then the sheriff arrived and talked to him.
- She saw no blood on FC #2.
- "I pushed him off me 3 times. I can't tell you where I made contact with him. He busted my lip but I have no idea how he did that."

Interview on 10/8/20 with FC #3 revealed:
- On 8/15/20, he had just got up from taking a nap and saw what occurred between FS #9 and FC #2. Client #1 was in the home as well as staff #2. Staff #2 was in the kitchen making dinner for part of the incident.
- FC #2 was put on restriction that day by FS #9 because he refused to take his medication. The medication FS #9 wanted FC #2 to take, was a

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medication he was supposed to take at another time.
- FC #2 hit FS #9 and then FS #9 threw FC #2 to the ground. FS #9 hurt FC #2.
- FC #2's mouth and arm were bleeding.
- FC #2 went outside where he did property damage. Staff A1, who worked next door at sister facility A, walked over to FC #2. Then law enforcement came to the group home.
- "[FS #9] pushed [FC #2] at first in the chest, and then [FC #2] got up and [FS #9] punched [FC #2] with a fist on the side of his jaw and then he got up a third time and [FS #9] punched with a fist on the arm. [FC #2] fell in the living floor and his arm got (unsure what part of his arm) cut on a piece of glass."

Interview on 10/8/20 with Staff A1 revealed:
- She worked in the sister facility A, which is next door to the Stickney House.
- On 8/15/20, she did not see what occurred inside the group home between FC #2 and FS #9. She only saw what occurred on the outside.
- She heard a desk on the front porch being thrown.
- She then went over to where FC #2 was located outside the home, he was trying to rip the electric meter box off the side of the house.
- FC #2 was easy to calm down then she talked to him.
- FC #2 reported to her that he was upset because he did not want to take his medicine at 5:00 pm and wanted to take it at 8:00 pm because it made him sleepy. He reported he had been to the doctor earlier that day. FC #2 also reported to her that FS #9 had her hands all up in his face and cursed at him. FC #2 seemed remorseful about what happened and said he never hit women. FC #2 told her if FS #9 had not put hands on him the incident would not have

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STICKNEY HOUSE	120 ROCKWELL LOOP MOORESVILLE, NC 28115

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occurred.
- FC #2 was also upset because FS #9 would not allow him to contact his Social Worker.
- She then noticed FS #9 started walking down the street on her phone. FC #3 walked up to her and FS #9. FC #3 said, "you know what really triggered [FC #2] was because [FS #9] kept threatening him with restrictions. She said that is two days, that is six days, that is 9 days, that is one month, that is two months and six days. She got all the way to 2 months and 6 days." FC #2 confirmed what FC #3 told her.
- FS #9 did not want to talk to her.
- FC #2 had a couple of scratches on his arm close to the wrist area. She felt that FS #9 scratched him because she observed FS #9's fingernail was broken on 8/15/20.
- None of the administrative staff ever talked to her about the incident but knew that she was involved because she responded to an 8/15/20 email that went out to all staff including the QP about the 8/15/20 incident. In her response she explained to everyone that she was the staff person who calmed down FC #2 when the incident occurred.
- "[FS #9] was more worked up that day than [FC #2] was."

Interview on 10/9/20 with the QA/QI #1 revealed:
- On 8/15/20, FS #9 facetimed her.
- FS #9 said that FC #2 was "flipping out." She could not recall why FC #2 "was flipping out."
- FS #9 showed her the property damage that was done by FC #2 inside the group home.
- She tried to talk to FS #9 and FC #2 and provide redirection but neither one would listen to the redirection she provided on facetime.
- She could see both FS #9 and FC #2 "throwing jabs at each other." FC #2 threw the first jab. She could see a bruise on FS #9's lip. Then FS #9's

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cell phone dropped.
- She contacted the QP and the OM and told them what transpired.
- "I think they (FS #9 and FC #2) got into an altercation. I heard scuffling back and forth. He stepped in her face first and [FS #9] did not back down."
- "[FS #9] defended herself, but she did not use any of the training she had."

Interview on 10/7/20 with staff #2 revealed:
- On 8/15/20 FC #2 did not want to get off the phone.
- FS #9 told FC #2 to put down the phone and come out of the office.
- When he came out of the office, he pulled things off the wall and threw them on the floor.
- She and FS #9 tried to calm down FC #2.
- FC #2 punched FS #9 on the lip because she got too close to FC #2.
- FC #2 ran outside and tried to pull the electric box off the side of the house.
- The police were called. FC #2 calmed down when the police came.
- "We could not do any type of restraint because [FC #2] is too big for us to restrain."
- Note: Attempted to do a follow-up telephone interview on 10/8/20, with staff #2 to question her about any injuries to FC #2 which was learned after her interview. She never returned the call.

Review on 10/9/20 of the "Employee Corrective Action Plan" dated 8/16/20 revealed:
- Employee Name: "[FS #9]"
- Signed by: QA/QI #1
- Action taken: Counseling Statement
- Explanation for Action: "[FS #9] called me (QA/QI #1) for help with a crisis. I didn't understand why chain of command wasn't used but answered to help. First thing I notice is the

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living qtrs.(quarters) are a wreck. It was clear property damage was done beyond measure. I asked her who did this and informed [FC #2]. I asked to speak with [FC #2], hoping to process.
- Employee Action Plan: "Employee will report to the office for meeting with HR regarding this issue as soon as possible."
- Further review revealed no documentation that FS#9 was removed from work the day of the incident.

Review on 10/14/20 of "Employee Documented Conversation" form revealed:
- The incident occurred on 8/15/20 but the form was not completed until 8/28/20
- Employee's Name: [FS #9]
- Signed by: the Human Resource Manager
- Date: 8/28/20
- Violation: "Violation of Company Policies"
- Employer's Statement: "[FS #9] attended a meeting on 8/28/20 to discuss an incident with client [FC #2]. In self-defense, employee push a client off of her after the client pushed/rushed her. Corrective Action Plan- Reiterated restraint/de-escalation techniques."
- Further review revealed no documentation that FS#9 was removed from work the day of the incident.

Review on 10/9/20 of the "Documentation of Staff Supervision Log" revealed:
- Written by: QA/QI #1
- FS #9 had supervision for the first time after the 8/15/20 incident on 8/20/20.
- Dates listed as supervision by QA/QI #1 of FS #9: 8/20/20, 8/21/20, and 8/26/20
- 9/2/20 supervision was listed as a "crisis"

Review on 10/15/20 of the Plan of Protection dated 10/15/20 written by the Licensee revealed:

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V 512	Continued From page 39 "What immediate action will the facility take to ensure the safety of the consumers in your care? 10A NCAC 27D .0304 An immediate policy change is being implemented which states that any employee that is involved in any type of physical incident with a client/staff is suspended from work until a complete and thorough investigation can be completed by [the AP] the alternate QP on staff who has experience performing Internal Investigations while working for CPS (Child Protective Services). An immediate policy change is being implemented which states that any employee that is involved in any type of physical incident with a client/staff is required to recertify in PMAB (prevention and management of aggressive behavior) de-escalation techniques prior to returning to work. An immediate policy change is being implemented which states that any employee that is involved in any type of physical incident with a client/staff is to be placed on a probation and is to receive regular overcite and training from a Rockwell Development Center QP. G.S. 131E -256 HCPR All Internal Investigations are to be completed by [the AP] the alternate QP on staff who has experience performing Internal Investigations while working for CPS. [The OM] is to be scheduled to receive 1 to 1 training with [the AP] to begin immediately on how to complete a proper Internal Investigation. [The AP] is to provide this training using the methodology she was trained on while working for CPS. 10A NCAC 27G .0604 [The QP] is to be scheduled immediately to complete refresher training on how to complete an IRIS report properly. Until that training is	V 512		

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completed all IRIS reports are to be completed by [the AP] the alternate QP on staff.
Describe your plans to make sure the above happens.
10A NCAC 27D .0304
The new policies have already been written and included in both the Policies and Procedures book as well as the employee handbook. Additionally, an email has been sent out to all staff informing them of the new policies.
G.S. 131E -256 HCPR
An email has been sent to [the AP], [the OM], and [the Human Resource Manager] informing them that all Internal Investigations are to be performed by [the AP] until such time as [the AP] feels that [the OM] can perform a thorough investigation of her own. All (3) parties were requested to acknowledge that they had received and read the email.
10A NCAC 27G .0604
An email was sent out at 3:06 pm on October 15, 2020 informing [the QP] of her citation and of her need to complete refresher training. I have requested that she provide me with the date she will have that training completed by. She has been instructed to have this information to me by no later than tomorrow."

The facility served 3 male clients (1 current client and 2 former clients. Two clients were 12 years of age and one was 16 with diagnoses included: Attention Deficit Hyperactivity Disorder; Disruptive Mood Dysregulation Disorder; and Anxiety Disorder. Treatment plans and discharge summaries revealed clients struggled with issues of: hitting objects and people when upset, severe abandonment issues, anger issues, runaway behaviors, emotional outbursts, making verbal and physical threats toward staff, coping with the recent death of a sibling, aggressive behaviors,

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V 512	Continued From page 41 anger, yelling, and swearing. There were 2 incidents of abuse, 1 incident of neglect and 2 incidents of failure to protect clients from abuse and neglect. On 9/2/20, FS #9 assaulted FC #3 when she grabbed him by his neck and threw him down on his bed. This resulted in scratch marks to the right side of his neck and a red mark to the side of his right eye. Then On 8/20/20, FS #9 tried to teach clients how to fight. On 8/15/20, FS #9 got into a power struggle with FC #2 over taking medication and FC #2 wanted to call his social worker. The power struggle started a "pushing battle" between FC #2 and FS #9. FC #2 indicated that FS #9 scratched his face. There were no internal investigations completed by the Operation Manager of the 3 incidents. The QP did not begin any type of supervison of FS #9 after the first incident on 8/15/20 until 8/20/20 and did not report updated information in IRIS about FS #9's pushing FC #2 and FS #9's behavior leading up to the 8/15/20 incident. FS#9 was not removed from the schedule after the first incident on 8/15/20 and was allowed to continue working with all the clients. This deficiency constitutes a Type A1 rule violation for serious abuse and neglect. This must be corrected within 23 days. An administrative penalty of $2,000.00 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 512		