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V 000	INITIAL COMMENTS A complaint and follow-up survey was completed on 10/2/20. The complaints were substantiated (Intakes #NC166868, #NC164106, #NC164264). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment Facility.	V 000		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures	V 109	DHSR-Mental Health NOV 02 2020 Lic. & Cert. Section	

Angie Brown MSLCMHC LCAS — Clinical Director — 10/29/2020

Clarence Lacy BSOP — Program Director

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Verified by PDF Filler
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amy N Brown MS LCMHC LCAS CSI CSOTP EMDR TFCBT
TITLE: Clinical Director
(X6) DATE: 10/29/2020

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Clarence Lawing BS QP
Program Director
10/29/2020

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V 109	Continued From page 1 for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure the Qualified Professional (QP) demonstrated competency for the population served for 1 of 1 QP/Case Manager. The findings are: Review on 9/23/20 of client #2's record revealed: -admission date of 11/12/19; -diagnoses of Conduct Disorder; -age 16 years; -treatment plan dated 10/31/19 had the following goals: 1)comply with all rules and expectations in setting, follow all directive, respect other's personal space, boundaries and property, 2)eliminate all physical and verbally aggressive behaviors, 3)improve relationships with peers, learn effective communication with peers and reduce aggressive behaviors; -treatment plan strategies included: staff provided monitoring 24 hours a day, 7 days a week, facilitated structured activities and utilized behavior management system and regular verbal and written feedback, implemented modified daily points plan with daily rewards for safe and positive behaviors, weekly therapy to explore triggers for aggression, teach skills to effectively	V 109	Placement of staff on the unit to create increased supervision will be addressed on night shift. (staffing to be handled by the Lead Residential Counselor Supervisor (LRCS) and the Program Director(PD)) Client will be monitored by a 1:1 staff from 5:30pm until client #2 falls asleep. This will ensure that client #2 is monitored during shift change and the time frame of client #2's increased behavior. (Staffing patterns will be monitored and implemented by the LRCS and PD) Clinical team consisting of the Case Manager(QP), the therapy department, and the Clinical Director (CD) will create Person-Centered Plan (PCP) strategies/interventions to assist client #2's impulsivity. Client #2 will have an individualized behavior support plan (BSP) created by the next Child Family Team meeting to be held on 10/27/2020. The CD will create the BSP and provide a competency on the BSP/Crisis Plan.	9/24/2020 10/5/2020 10/27/2020 10/27/2020

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V 109	Continued From page 2 manage anger and aggression, process group to increase positive communication and problem solving skills, psychiatrist once a week to evaluate effectiveness of medications, provide recommendations and assessments, nursing to administer medications on a daily basis and provide daily monitoring of health; -goals and strategies were reviewed eleven times in the past year with no updates made by the QP to address client #2's continued aggression towards peers. Review on 10/2/20 of the QP/Case Manager's record revealed: -date of hire was 12/23/19; -documentation of all required completed trainings present in the record. Review on 9/22/20 of the facility incident reports from 6/1/20-9/22/20 revealed: -client #2 engaged in physical aggression with peers/attacked peers on the following dates: 6/19, 6/20, 6/25, 7/5, 7/21, 7/26, 8/1, 8/24, 8/30 and 9/5; -6/25 peer sustained a head concussion during an altercation with client #2; -8/1 peer sustained abrasions on right upper chest, neck and back as a result of an altercation with client #2; -8/24 peer had cuts to lower and upper left lip and slight swelling of jaw as a result of a physical attack by client #2; -8/30 peer had a bruise and scratch as a result of a physical attack by client #2. Interview on 10/2/20 with the QP/Case Manager revealed: -job title of Case Manager; -responsible for the treatment plans for the clients;	V 109	Client #2 will have individualized recreation time daily. (LRCS and PD will ensure staffing ratio accomodates the time) Client #2's individual therapy will increase to twice a week for check-ins. (Therapy Department and CD) Clinical Team will create a crisis plan with triggers and coping skills to ensure that Residential Counselors (RC) and all facility staff (teachers, QP, etc) are familiarized (initially upon intake) with each client's triggers, target behaviors, and coping skills. The QP will review all facility client's crisis plan during the monthly Child and Family Team (CFT) meetings and update as needed. LRCS, PD and CD will randomly check on staff using the video cameras thoroughout the facility. The CD will create a log to show the spot checks being completed by the LRCS, PD and CD. LRCS, PD and CD or another clinical staff as assigned (therapist, QP, Shift leads) will do random fidelity checks using a fidelity checklist to ensure RC competency for crisis plans (triggers, target behaviors and coping skills). New Hire Training will include client specific training on all facility client's crisis plans and take a competency quiz to ensure knowledge and understanding of the client's crisis plans. New Hire Training will be conducted by the CD or designated trainer. LRCS will continue to conduct individual and group supervision monthly to address the needs of facility staff and clients. The LRCS will provide feedback to staff during supervision and additional training as needed. The LRCS, PD and CD will provide hands on training in positive behavior support interventions through "teachable moments" when the staff are on shift.	10/5/2020 10/16/2020 10/29/2020 & ongoing 10/12/2020 10/29/2020 & ongoing 10/29/2020 & ongoing ongoing 10/29/2020 & ongoing

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V 109	Continued From page 3 -"I was going to update his(client #2's) goals; -"I was going to meet with the Clinical Director and the therapist to update goals;" -"Just had CFT(Child and Family Team) this week;" -"in process of updating his(client #2's) goals;" -"Talked about all of this in CFT;" -"looking at a lateral move;" -"review his(client #2's) information, meeting to discuss it;" -"been here so long he's lost the motivation;" -"Has potential to do better;" -"He needs a new environment;" -"Only thing I am aware of is the daily point system like for all kids for direct staff to do;" -not aware of anything else in place for client #2 to address his continued aggression; -staff talk to client #2 one on one; -staff process through conflict with client #2; -not aware of any specific behavioral plan for client #2 to address his aggression. Review on 10/2/20 of documentation from a CFT Meeting for client #2 dated 9/30/20 completed by the QP/Case Manager revealed the following: -update on client #2's therapy sessions on 8/6, 8/14, 8/20 and 8/27 addressing triggers for anger, his negative behaviors and consequences, utilization of relaxation skills, coping skills for anger and the incident when he ran through a bathroom and attacked a peer; -school progress updated; -client #2 engaged in a physical altercation with a peer on 8/1; -client #2 assaulted a peer on 8/30; -"[Client #2] continues to struggle with aggressive and defiant behaviors that indicate severity of mental health diagnoses concerns of stepping down due to continued level of aggressive behaviors. If he continues to show these	V 109		

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V 109	Continued From page 4 behaviors, the team will consider looking for a lateral move for him;" -no documentation of discussion regarding need for updated strategies/interventions to address client #2's continued significant aggression towards peers. Refer to V112 for an example of failure to develop and implement strategies to address client needs. This deficiency is cross referenced into 10A NCAC 27G .1901 Residential Treatment Staff Secure for Children and Adolescents-Scope V314 for a Type A1 rule violation and must be corrected within 23 days.	V 109		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills;	V 110	LRCS, PD and CD or another clinical staff as assigned (therapist, QP, Shift leads) will do random fidelity checks using a fidelity checklist to ensure RC competency for crisis plans (triggers, target behaviors and coping skills). LRCS will continue to conduct individual and group supervision monthly to address the needs of facility staff and clients. The LRCS will provide feedback to staff during supervision and additional training as needed. The LRCS, PD and CD will provide hands on training in positive behavior support interventions through "teachable moments" when the staff are on shift. LRCS, PD and CD will randomly check on staff using the video cameras thoroughout the facility. The CD will create a log to show the spot checks being completed by the LRCS, PD and CD.	10/29/2020 & ongoing ongoing ongoing 10/5/2020

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V 110	Continued From page 5 (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure paraprofessionals demonstrated competency for the population served for 1 of 7 current staff(#2) and 1 of 1 former staff (FS#8). The findings are: Review on 9/23/20 and 10/2/20 of client #2's record revealed: -admission date of 11/12/19; -diagnoses of Conduct Disorder; -age 16 years; -CCA(Comprehensive Clinical Assessment) dated 10/1/19 documented client #2 was on long term expulsion from school for taking a loaded gun to school, destroyed property, engaged in fights with his siblings and was known to carry weapons; -treatment plan dated 10/31/19 had goals which included elimination all physical and verbally aggressive behaviors, learn effective communication with peers and reduce aggressive behaviors; -treatment plan strategies included: staff provided monitoring 24 hours a day, 7 days a week,	V 110	Client will be monitored by a 1:1 staff from 5:30pm until client #2 falls asleep. This will ensure that client #2 is monitored during shift change and the time frame of client #2's increased behavior. (Staffing patterns will be monitored and implemented by the LRCS and PD). Placement of staff on the unit to create increased supervision will be addressed on night shift. (staffing to be handled by the Lead Residential Counselor Supervisor (LRCS) and the Program Director(PD)) Clinical team consisting of the Case Manager(QP), the therapy department, and the Clinical Director (CD) will create Person-Centered Plan (PCP) strategies/interventions to assist client #2's impulsivity. Client #2's individual therapy will increase to twice a week for check-ins. (Therapy Department and CD)	10/5/2020 10/27/2020 10/27/2020 10/16/2020

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V 110	Continued From page 6 facilitated structured activities and utilized behavior management system and regular verbal and written feedback, implemented modified daily points plan with daily rewards for safe and positive behaviors, weekly therapy to explore triggers for aggression, teach skills to effectively manage anger and aggression, process group to increase positive communication and problem solving skills, psychiatrist once a week to evaluate effectiveness of medications, provide recommendations and assessments, nursing to administer medications on a daily basis and provide daily monitoring of health. Review on 9/23/20 of Former Client(FC)#4's record revealed: -admission date of 4/2/20; -discharge date of 7/31/20; -age 14 years; -diagnosis of Adjustment Disorder with mixed disturbance of emotions and conduct and Reactive Attachment Disorder; -admission assessment dated 3/19/20 documented FC#4 had behaviors/issues which included verbal aggression, dishonesty, suicidal ideation, depression and opposition. His aggression was triggered by fearfulness; -treatment plan dated 4/1/20 had goals which included develop skills needed to resolve conflict positively, learn skills to control anger, identify triggers cause anger, learn ways to express disagreements with other without combative, evasive, argumentation, aggressive or destructive; -therapy updates in treatment plan documented FC#4 was having difficulties processing his father's passing. On 5/31/20, a letter was found that eluded to suicide. FC#4 was assessed for suicide by his therapist and placed on suicide watch for 48 hours;	V 110		

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V 110	Continued From page 7 -monthly treatment plan review/update on 6/3/20 documented the following incident was discussed: "[FC#4] continues to struggle with his goal to manage his anger. [FC#4] noticed his pictures(of his deceased father) that were on his wall ripped up by one of his peers(client #2). Staff attempted to try to keep him calm, reminding him of his coping skills. He started to become more upset and started threatening his peer(client #2). [FC#4] began being disrespectful towards staff cursing and calling staff names. [FC#4] started to become more upset and tried to use physical force towards staff and nurse to get peer(client #2) from his room...[FC#4] came at staff trying to swing his arm which forced staff to use physical intervention..." Review on 9/23/20 of Former Client(FC)#7's record revealed: -admission date of 5/8/20; -discharge date of 9/11/20; -age 15 years; -diagnosis of Intermittent Explosive Disorder, ADHD and IDD; -CCA dated 4/29/20 documented FC#7 was difficult to engage, ran away, lacked insight, needed to not engage in illegal acts and needed to increase his compliance; -treatment plan dated 4/15/20 had goals which included : elimination of all physically and verbally aggressive behaviors, learn and implement effective coping skills to combat negative feelings associated with compliance, learn skills to better coping with anger, communicate effectively, managing aggressive and destructive impulses. Review on 9/24/20 of staff #2's personnel record revealed: -hire date of 7/21/19 with job title of Residential Counselor;	V 110		

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V 110	Continued From page 8 -documentation of all required completed trainings were present in the record. Review on 9/24/20 of FS#8's personnel record revealed: -hire date of 3/27/20 with job title of Residential Counselor; -resigned on 7/31/20; -documentation of all required completed trainings were present in the record. Review on 9/22/20 of a Level II incident report dated 6/25/20 at 7:53pm regarding FC#4 revealed the following documented: "Consumer(FC#4) started arguing with a peer(FC#7) about a chair. Consumer became involved in a physical altercation with peers(FC#7 and client #2). Staff used a restrictive movement to try and keep consumer and peers separated. Nurse checked out consumer and recommended calling EMS(Emergency Medical Services). EMS came on to the facility and transported consumer to the ER(Emergency Room) for further care. Consumer sustained a concussion from this incident and is being closely monitored by nurse and staff." Review on 9/22/20 of a discharge summary from a local ER dated 6/25/20 regarding FC#4 documented the discharge diagnosis as: "Assault, Brain Concussion." Interview on 9/25/20 with staff #2 revealed: -worked at the facility for over a year; -worked night shift 6:30am-6:30pm; -had trainings in EBPI, de-escalation and MH diagnoses; -recent training on how to identify triggers of clients; -worked the night of the incident with client #2,	V 110		

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V 110	Continued From page 9 FC#4 and FC#7; -"situation happened in the spur of the moment;" -had a "bad thought in my head;" -client #2 and FC#4 went back and forth at each other; -"Felt alittle iffy" about FC#4 and client #2 going downstairs together; -"I think I even talked to the other staff about it;" -"Didn't pay attention to it" because one minute client #2 and FC#4 didn't get along, and the next minute they were friends; -there was no prior conflict between FC#7 and FC#4; -FC#4 had been talking too much to FC#7 prior; -everyone was upstairs in a group going over rules before client #2, FC#7 and FC#4 went downstairs; -FC#4 wanted to go downstairs; -Staff #2 stayed upstairs with other clients; -Registered Nurse(RN)#1 radioed staff #3 to go downstairs to assist; -Staff #3 went down pretty quick; -FS#8 had a radio issue; -FS#8 "did the best he could;" -had about 9-10 kids that night. Interview on 9/25/20 with FS#8 revealed: -worked night shift at the facility; -had trainings in EBPI, verbal de-escalation, use restraint as last resort, behaviors and mental health diagnoses and how to handle client behaviors; -clients were upstairs on the unit; -there were three staff: FS#8, staff #2 and staff #3 as well as RN#1; -clients who were not on restriction got the privilege to go downstairs and watch television or have time on the computer; -client #2, FC#7 and FC#4 were not on restriction and were able to go downstairs;	V 110		

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V 110	Continued From page 10 -had already noticed some prior "animosity" between client #2, FC#7 and FC#4; -knew client #2 and FC#7 did not like FC#4; -tried to get FC#4 to remain upstairs on the unit; -FC#4 was adamant he wanted to go downstairs; -even discussed his concerns with his co-worker staff #2; -"Was trying to look for him(FC#4);" -thought "the other kids might do something;" -noticed earlier they(client #2, FC#7 and FC#4) were staring at each other, going back and forth; -let FC#4 go downstairs because it was a privilege and he had earned it; -there were 9 kids at the facility that night; -FS#8 went downstairs with client #2, FC#4 and FC#7; -other staff stayed upstairs with the rest of the clients; -FC#4 threw a cup of water at FC#7, and FC#7 started to hit FC#4; -FC#4, FC#7 and client #2 got into a physical altercation; -saw client #2 hit FC#4 and FC#4's head recoiled back then hit the ground; -FC#4 curled up in a fetal position on the ground; -"Bothered me that happened to him(FC#4);" -"They(client #2 and FC#7) got the better of [FC#4];" -client #2 and FC#7 "went above and beyond to hurt that kid(FC#4);" -"Did the best we could do" trying to handle the incident; -there was a lead staff on duty during the night shift; -he dealt with staff #2 on his shift; -he resigned his position; -"Too much going on. Did not want to deal with it anymore." Interview on 9/24/20 with RN#1 revealed:	V 110		

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V 110	Continued From page 11 -got a call from staff #3 saying she needed a nurse in the cafeteria; -came into the cafeteria and observed FC#4 laying on the ground; -ran over and assessed FC#4. -he was slow to respond; -she wasn't sure what happened; -she was concerned for a head injury; -she stepped into the classroom and saw FS#8, FC#7 and client #2; -she asked what happened; -FC#7 said he punched FC#4; -staff called EMS. She stayed with FC#4 until EMS arrived; -FC#4 had slow verbal response, slow pain response, slight altered mental status, red marks on his upper body and blood inside his nostril. She saw no open wounds and no other blood; -by the time EMS arrived, FC#4 was more alert, more oriented and answered questions appropriately. EMS took FC#4 to the hospital for evaluation; -FC#4 was discharged back to the facility with a diagnosis of Concussion and Assault; -the police arrived also. She went in with the police to talk to client #2 and FC#7 with FS#8; -client #2 and FC#7 stated they beat FC#4 up. They didn't say where or how they hit FC#4; -FS#8 was standing there "like in shock;" -Staff working that night included her, FS#8, staff #2 and a third staff on the unit. FS#8 had gone downstairs with the three boys. She and the third staff had stayed on the unit while staff #3 went downstairs to get snacks. Attempts to interview staff #3 on 9/25/20, 9/28/20(two times) and 9/30/20 were unsuccessful as there were no answers to the attempted phone calls, and no voicemail set up to take messages.	V 110		

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V 110	Continued From page 12 Interview on 9/30/20 with FC#4 revealed: -remembered the fight with client #2 and FC#7; -was upstairs after dinner and did showers; -clients who got in trouble were not allowed to go downstairs after dinner. Only clients who were not in trouble got to go downstairs; -he, client #2 and FC#7 were the only clients that day who were not in trouble; -it was about 7:30pm-8:00pm; -went downstairs with FS#8; -FS#8 was the only staff who went downstairs with them(client #2, FC#4 and FC#7); -staff #2, staff #3 and Registered Nurse(RN)#1 were upstairs with the other clients; -he sat down in a seat he had been assigned to all that day in the classroom; -FC#7 came up to him and said he was in his (FC#7's) seat; -he and FC#7 were arguing about the seat; -FS#8 was sitting down in a seat behind the desk and told them both to calm down; -FC#7 was cussing at him, and FC#7 came at him like he(FC#7) was going to attack him; -FC#4 dropped his water, stood up and "I slid up" on the ground; -FC#7 began punching FC#4 and they started fighting; -FS#8 tried to break it up but he "couldn't physically;" -a couple of seconds after he and FC#7 started fighting, client #2 jumped in; -"They jumped me;" -FS#8 never called for help on his radio like he was supposed to; -the fight ended up in the cafeteria; -somebody hit him the last time. He did not remember who hit him; -"I think I blacked out;" -he woke up and saw RN#1. He was on the	V 110		

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V 110	Continued From page 13 cafeteria floor. He had a sharp pain in his neck, close to his spine and his nose hurt. He was bleeding from his nose; -they(staff) called the ambulance and he went to the hospital; -prior to this fight, he and client #2 did not get along. Client #2 and FC#7 had stolen some of his belongings. Client #2 went in his room and tore up his pictures of his recently deceased father. He was very upset; -been in altercations with client #2 in the past. Interview on 9/24/20 with client #2 revealed: -was in the classroom beside the cafeteria watching television; -FC#4 started talking and saying stuff to FC#7; -FC#4 threw water at him and FC#7; -FC#4 and FC#7 got in a fight; -"Me and [FS#8] broke it up;" -"They just fighting;" -"[FS#8] trying to break it up. He couldn't get to his radio. [FC#4] kept opening door, classroom door;" -he and FC#4 started fighting. He hit FC#4 a couple of times; -FC#7 got loose, "I don't know how;" -he hit FC#4 and FC#4 fell; -FC#7 hit FC#4; -FC#4 balled up on ground, crying, "don't hit me;" -feel staff watch them close; -probably "get wrapped up with each other, fist is thrown, most likely don't hit them(peers) because of staff." Attempts to interview FC#7 on 9/25/20 and 9/30/20 were unsuccessful as the legal guardian did not provide contact information for FC#7 at his current placement. Review on 9/24/20 of staff meetings/supervision	V 110		

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V 110	Continued From page 14 documentation prior to the 6/25/20 incident involving client #2, FC#4 and FC#7 revealed the following: -5/29/20 topics discussed included supervision of clients and paying attention to triggers for behaviors; -6/12/20 topics discussed included supervision of all clients, watching for triggers/behaviors and de-escalation of clients. This deficiency is cross referenced into 10A NCAC 27G .1901 Residential Treatment Staff Secure for Children and Adolescents-Scope V314 for a Type A1 rule violation and must be corrected within 23 days.	V 110		
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	V 112	Update to crisis plans monthly to ensure new informatoin regarding triggers, target behaviors, interventions and coping skills are up-to-date for each client during the monthly CFT meetings. The CD will monitor update and revisions completed by the QP/Case Manager by reviewing the documentation monthly to ensure that updates and revisions have taken place. The CD will note the client's chart in OnTarget (EHR) monthly when audit is complete. Clinical Team will create a crisis plan with triggers and coping skills to ensure that Residential Counselors (RC) and all facility staff (teachers, QP, etc) are familiarized (initially upon intake) with each client's triggers, target behaviors, and coping skills. The QP will review all facility client's crisis plan during the monthly Child and Family Team (CFT) meetings and update as needed.	10/27/2020 & ongoing 10/27/2020 & ongoing

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V 112	Continued From page 15 responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure strategies were developed and implemented to address client needs affecting 1 of 3 current clients (#2). The findings are: Review on 9/23/20 of client #2's record revealed: -admission date of 11/12/19; -diagnoses of Conduct Disorder; -age 16 years; -treatment plan dated 10/31/19 had the following goals: 1)comply with all rules and expectations in setting, follow all directive, respect other's personal space, boundaries and property, 2)eliminate all physical and verbally aggressive behaviors, 3)improve relationships with peers, learn effective communication with peers and reduce aggressive behaviors; -treatment plan strategies included: staff provided monitoring 24 hours a day, 7 days a week, facilitated structured activities and utilized behavior management system and regular verbal and written feedback, implemented modified daily points plan with daily rewards for safe and positive behaviors, weekly therapy to explore triggers for aggression, teach skills to effectively manage anger and aggression, process group to	V 112	Update to crisis plans monthly to ensure new informatoin regarding triggers, target behaviors, interventions and coping skills are up-to-date for each client during the monthly CFT meetings. The CD will monitor update and revisions completed by the QP/Case Manager by reviewing the documentation monthly to ensure that updates and revisions have taken place. The CD will note the client's chart in OnTarget (EHR) monthly when audit is complete. Clinical Team will create a crisis plan with triggers and coping skills to ensure that Residential Counselors (RC) and all facility staff (teachers, QP, etc) are familiarized (initially upon intake) with each client's triggers, target behaviors, and coping skills. The QP will review all facility client's crisis plan during the monthly Child and Family Team (CFT) meetings and update as needed. LRCS, PD and CD or another clinical staff as assigned (therapist, QP, Shift leads) will do random fidelity checks using a fidelity checklist to ensure RC competency for crisis plans (triggers, target behaviors and coping skills). LRCS, PD and CD will randomly check on staff using the video cameras thoroughout the facility. The CD will create a log to show the spot checks being completed by the LRCS, PD and CD.	10/27/2020 & ongoing

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V 112	Continued From page 16 increase positive communication and problem solving skills, psychiatrist once a week to evaluate effectiveness of medications, provide recommendations and assessments, nursing to administer medications on a daily basis and provide daily monitoring of health; -Crisis Plan documented client #2 displayed behaviors of stealing, lying, damaging property, running away, balled fists, less talkative, hitting or kicking somebody or something, kicking a wall over and over, going to his room and shutting his door, yelling and cursing, name calling. Crisis Plan strategies included talking to him about the situation, allowing him time to calm down, letting him draw, giving him a stress ball, let him go for a walk, allow him to listen to music, play basketball, separate him from the group, talk to staff he has a rapport with and don't try to tell him what to do when he was upset; -goals and strategies were reviewed eleven times in the past year with no updates to address client #2's continued aggression towards peers. Review on 9/22/20 of the facility incident reports from 6/1/20-9/22/20 revealed the following: -6/19 Client #2 tried to fight a peer, restrained; -6/20 Client #2, attacked a peer, separated by staff, restrained; -6/25 FC(Former Client)#4 got into an altercation with client #2 and FC#7, resulted in FC#4 sustaining a head concussion; -7/5 Client #2 attacked a peer; -7/21 Client #2 tried to fight a peer/attack staff, escorted to his room -7/26 Client #2 tried to fight a peer, separated; -8/1 Client #2 got into a physical altercation with a peer; -8/24 Client #2 ran through the bathroom door and assaulted a peer(client #3); -8/24 Client #3 was sitting on his bed getting	V 112		

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V 112	Continued From page 17 ready to go to sleep and another peer(client #2) came into his room from the bathroom entrance and physically attacked him(client #3). Staff stopped it and got peer(client #2) out of room. Client #3 sustained small cuts to lower and left upper lip and slight swelling of the jaw; -8/30 Client #2 went into a peer's (FC#6) room, picked him up and threw him(FC#6) on the bed. Client #2 hit FC#6 in the arm and the nose. Client #2 grabbed FC#6 and would not get off of him. Staff used EBPI(Evidence Based Protective Intervention) restrictive movement to remove client #2 off of FC#6 and escort client #2 back to his room; 8/30 FC#6 was in his room, peer(client #2) ran into his room, threw him on the bed and punched him(FC#6) in his arm, head and scratched FC#6 on his hands. Clients were separated. FC#6 sustained a bruise on his left arm and a scratch on his right hand; -9/5 Client #2 started an altercation with two peers causing staff to use restrictive interventions to separate peers. Interview on 9/28/20 with staff #1 revealed: -worked first shift at the facility; -been there over two years; -had trainings in client behaviors and mental health diagnoses; -client #2 did really good some weeks and then some weeks it was a constant struggle day to day to keep him on task; -client #2 was easily agitated and easily triggered; -said "good morning" and it set him off; -it depended on how client #2 was feeling; -client #2 liked to play and joked a lot with his peers; -the rule was no touching each other at all; -had to constantly process with client #2 about keeping his hands to himself;	V 112		

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V 112	Continued From page 18 -had to separate client #2 from his peers. Interview on 9/25/20 with staff #2 revealed: -client #2 did not have any triggers unless he got bored or wanted attention; -client #2 did really good, then he did something to get in trouble like steal something or "pick a fight with someone;" -used interventions with client #2 such as gave him a soccer ball he played with in his room; -was straight-forward with client #2; -talked to client #2 about his past and what he can do to do better; -"I always stay close to [client #2];" -client #2 sought attention; -client #2 did not start a lot of negative things, but he was involved in a lot of aggressive incidents; -noticed when a new client was admitted to the facility, client #2 liked to show the new client he was the troubled kid at the facility. Interview on 9/28/20 with staff #4 revealed: -client #2 liked to horseplay a lot; -wrestling and horseplay was not allowed; -"Tell them not to horseplay or touch each other because it leads to fights;" -client #2 was unpredictable; -let client #2 calm down; -ignored him and he stopped; -if client #2 got agitated or yelled, sent him to his room; -if client #2 came out of his room, he started disrupting and running around; -"We probably need more training on [client #2]." Interview on 9/28/20 with staff #5 revealed: -"He(client #2) argues with every kid down there;" -"You gotta be dead on" when dealing with client #2; -"when you see him(client #2) jumping and	V 112		

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V 112	Continued From page 19	V 112		

playing, get him to go back up to the unit, tell him we ain't gonna do what you think you're gonna do;"
-"His(client #2's) picking and laughing gonna turn into something serious real fast."

Interview on 9/23/20 with staff #6 revealed:
-client #2 had outbursts for no reason;
-client #2 cussed staff, threw chairs and was aggressive against staff;
-client #2 escalated over nothing;
-he wanted to get recognition from other clients;
-ongoing behaviors since client #2 has been here;
-sometimes not able to go straight into talking to client #2;
-have to give client #2 time to wind down;
-always processed with client #2 once he was calm and he understood what he did was for nothing;
-thinks he's scared to leave the facility;
-client #2's aggression not decreased at all;
-might decrease for a little bit;
-he might have three or four good days then right back.

Interview on 9/23/20 with staff #7 revealed:
-worked first shift 6:30am-6:30pm;
-not a lot of major issues with client #2 on his shift;
-client #2 did not really fight or attack people on his shift;
-tried to get client #2 to calm down;
-client #2 didn't stay calm if a peer said something to him;
-he turned right back up;
-client #2 acted like he had something to prove;
-had a lot of talks with client #2 about he had nothing to prove.

Interview on 9/23/20 with Registered Nurse(RN)

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V 112	Continued From page 20 #3 revealed: -client #2 was confrontational; -had gotten better since his medications were adjusted; -client #2 now on an injection; -been a lot better; -started with monthly injections; -now injections every two weeks; -was on Invega for a month; -now on Risperdal 37.5mg; -next dose is 50mg, next step up; -client #2 used to be unpredictable but now will separate himself and back down. Interview on 9/24/20 and 10/2/20 with the Residential Staff Supervisor(RS Sup) revealed: -client #2 was a unique situation, -was from a congested home, had a lot of siblings and cousins, and was raised by his aunt; -client #2 didn't want to go back to his aunt's, -he didn't get attention at his aunt's so he did things; -he antagonized peers, the smaller kids; -client #2 was very competitive; -client #2 displayed cussing, fighting, verbal and physical aggression; -he knew if he can stay straight for 30 days, another placement will look at him; -he sabotaged(a discharge to a lower level of care); -he loved attention; -if he did not get it, he caused it; -client #2 very slick and conniving; -client #2 saw opportunity, and he took it; -some interventions put in place for client #2 in response to the incidents included client #2 had recreation alone with staff one on one; -then only allowed client #2 to go out for recreation with other consumers supervised by staff he(the RS Sup) trusted.	V 112		

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V 112	Continued From page 21 This deficiency is cross referenced into 10A NCAC 27G .1901 Residential Treatment Staff Secure for Children and Adolescents-Scope V314 for a Type A1 rule violation and must be corrected within 23 days.	V 112		
V 314	27G .1901 Psych Res. Tx. Facility - Scope 10A NCAC 27G .1901 SCOPE (a) The rules in this Section apply to psychiatric residential treatment facilities (PRTF)s. (b) A PRTF is one that provides care for children or adolescents who have mental illness or substance abuse/dependency in a non-acute inpatient setting. (c) The PRTF shall provide a structured living environment for children or adolescents who do not meet criteria for acute inpatient care, but do require supervision and specialized interventions on a 24-hour basis. (d) Therapeutic interventions shall address functional deficits associated with the child or adolescent's diagnosis and include psychiatric treatment and specialized substance abuse and mental health therapeutic care. These therapeutic interventions and services shall be designed to address the treatment needs necessary to facilitate a move to a less intensive community setting. (e) The PRTF shall serve children or adolescents for whom removal from home or a community-based residential setting is essential to facilitate treatment. (f) The PRTF shall coordinate with other individuals and agencies within the child or adolescent's catchment area. (g) The PRTF shall be accredited through one of the following; Joint Commission on Accreditation	V 314	LRCS, PD and CD or another clinical staff as assigned (therapist, QP, Shift leads) will do random fidelity checks using a fidelity checklist to ensure RC competency for crisis plans (triggers, target behaviors and coping skills). LRCS will continue to conduct individual and group supervision monthly to address the needs of facility staff and clients. The LRCS will provide feedback to staff during supervision and additional training as needed. The LRCS, PD and CD will provide hands on training in positive behavior support interventions through "teachable moments" when the staff are on shift. New Hire Training will include client specific training on all facility client's crisis plans and take a competency quiz to ensure knowledge and understanding of the client's crisis plans. New Hire Training will be conducted by the CD or designated trainer. All Residential Counselors (RC) and RC Leads will be trained on all new clients prior to admission on the client's Crisis Plan and/or Behavior Support Plan. The facility staff will take a competency quiz to ensure staff understand the new client's crisis plan, person-centered plan (PCP) and/or behavior support plan (BSP) as well as the client's diagnosis. The training will take place in the staff meeting prior to the new client being admitted into the facility. The PD/CD will ensure that any updated/revised crisis plans are reviewed and staff trained on the updates/revisions during the month of the client's CFT meeting, if any updates/revisions have taken place.	10/29/2020 & ongoing current & ongoing 10/29/2020 & ongoing New Hire training 10/29/2020 & ongoing 10/29/2020 & ongoing

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V 314	Continued From page 22 of Healthcare Organizations; the Commission on Accreditation of Rehabilitation Facilities; the Council on. Accreditation or other national accrediting bodies as set forth in the Division of Medical Assistance Clinical Policy Number 8D-1, Psychiatric Residential Treatment Facility, including subsequent amendments and editions. A copy of Clinical Policy Number 8D-1 is available at no cost from the Division of Medical Assistance website at http://www.dhhs.state.nc.us/dma/. This Rule is not met as evidenced by: Based on records review, interviews and observations, the facility failed to provide a structured living environment with supervision and specialized interventions on a 24-hour basis and failed to provide therapeutic interventions addressing functional deficits associated with the child or adolescent's diagnosis affecting 2 of 3 current clients(#2, #3) and 4 of 4 former clients(FC#4, FC#5, FC#6, FC#7). The findings are: Cross Reference: 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS V109 Based on records review and interviews, the facility failed to ensure the Qualified Professional (QP) demonstrated competency for the population served for 1 of 1 QP/Case Manager. Cross Reference: 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF	V 314	LRCS, PD and CD or another clinical staff as assigned (therapist, QP, Shift leads) will do random fidelity checks using a fidelity checklist to ensure RC competency for crisis plans (triggers, target behaviors and coping skills). LRCS will continue to conduct individual and group supervision monthly to address the needs of facility staff and clients. The LRCS will provide feedback to staff during supervision and additional training as needed. The LRCS, PD and CD will provide hands on training in positive behavior support interventions through "teachable moments" when the staff are on shift. New Hire Training will include client specific training on all facility client's crisis plans and take a competency quiz to ensure knowledge and understanding of the client's crisis plans. New Hire Training will be conducted by the CD or designated trainer. All Residential Counselors (RC) and RC Leads will be trained on all new clients prior to admission on the client's Crisis Plan and/or Behavior Support Plan. The facility staff will take a competency quiz to ensure staff understand the new client's crisis plan, person-centered plan (PCP) and/or behavior support plan (BSP) as well as the client's diagnosis. The training will take place in the staff meeting prior to the new client being admitted into the facility. The PD/CD will ensure that any updated/revised crisis plans are reviewed and staff trained on the updates/revisions during the month of the client's CFT meeting, if any updates/revisions have taken place.	10/29/2020 & ongoing current & ongoing 10/29/2020 & ongoing New Hire training 10/29/2020 & ongoing 10/29/2020 & ongoing

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V 314	Continued From page 23 PARAPROFESSIONALS V110 Based on records review and interviews, the facility failed to ensure paraprofessionals demonstrated competency for the population served for 1 of 7 current staff(#2) and 1 of 1 former staff (FS#8). Cross Reference: 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN V112 Based on records review and interviews, the facility failed to ensure strategies were developed and implemented to address client needs affecting 1 of 3 current clients (#2). Cross Reference: 10A NCAC 27F .0104 STORAGE AND PROTECTION OF CLOTHING AND POSSESSIONS V541 Based on records review and interviews, the facility failed to ensure each client's personal clothing and possessions were protected from theft, damage, destruction, loss, and misplacement affecting 1 of 4 former clients (FC#4). Review on 9/22/20 of the facility incident reports from 6/1/20-9/22/20 revealed the following: -8/24 Client #2 ran through the bathroom door and assaulted a peer(client #3); -8/24 Client #3 was sitting on his bed getting ready to go to sleep and another peer(client #2) came into his room from the bathroom entrance and physically attacked him(client #3). Staff stopped it and got peer out of room. Client #3 sustained small cuts to lower and left upper lip and slight swelling of the jaw; -8/30 Client #2 went into a peer's (FC#6) room, picked him up and threw him on the bed. Client #2 hit FC#6 in the arm and the nose. Client #2 grabbed FC#6 and would not get off of him. Staff used EBPI(Evidence Based Protective Intervention) restrictive movement to remove	V 314	LRCS, PD and CD or another clinical staff as assigned (therapist, QP, Shift leads) will do random fidelity checks using a fidelity checklist to ensure RC competency for crisis plans (triggers, target behaviors and coping skills). (see attached fidelity checklist) LRCS will continue to conduct individual and group supervision monthly to address the needs of facility staff and clients. The LRCS will provide feedback to staff during supervision and additional training as needed. The LRCS, PD and CD will provide hands on training in positive behavior support interventions through "teachable moments" when the staff are on shift. New Hire Training will include client specific training on all facility client's crisis plans and take a competency quiz to ensure knowledge and understanding of the client's crisis plans. New Hire Training will be conducted by the CD or designated trainer. All Residential Counselors (RC) and RC Leads will be trained on all new clients prior to admission on the client's Crisis Plan and/or Behavior Support Plan. The facility staff will take a competency quiz to ensure staff understand the new client's crisis plan, person-centered plan (PCP) and/or behavior support plan (BSP) as well as the client's diagnosis. The training will take place in the staff meeting prior to the new client being admitted into the facility. (see attached competency quiz and training) The PD/CD will ensure that any updated/revised crisis plans are reviewed and staff trained on the updates/revisions during the month of the client's CFT meeting, if any updates/revisions have taken place. An updated/revised new client admission personal items checklist (checklist will be included in the facility intake packet) created by the CD will outline what specific items are allowed to be brought to the facility upon admission. Personal belongings will continue to be inventoried upon admission and locked in anoather locate to prevent theft. The LRCS will assign a RC to complete the inventory checklist to ensure nothing not on the list is brought into the facility. (see attached personal items checklist revised)	10/29/2020 & ongoing current & ongoing 10/29/2020 & ongoing New Hire training 10/29/2020 & ongoing 10/29/2020 & ongoing 10/29/2020 & ongoing 10/29/2020 & ongoing

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V 314	Continued From page 24 client #2 off of FC#6 and escort client #2 back to his room; -8/30 FC#6 was in his room, peer(client #2) ran into his room, threw him on the bed and punched him in his arm, head and scratched FC#6 on his hands. Clients were separated. FC#6 sustained a bruise on his left arm and a scratch on his right hand. Interview on 9/28/20 with staff #4 revealed: -was working the night client #2 ran into FC#6's room and went through bathroom to client #3's room; -bedrooms had a connecting bathroom; -client #2 tried to attack client #3; -client #2's bedroom was opposite corner near back stairs. FC#6's room was second bedroom on right coming into the unit from the front stairs; -a bathroom connected FC#6's room to client #3's room. Client #3's room was the first bedroom to the right; -client #2 ran from his room into FC#6's room, through the bathroom and into client #3's room; -client #2 ran past him and staff #5; -he and staff #5 were standing right there; -he was closest to client #2 when he ran by him(staff #4) -there was a commotion going on with some other clients; -he had opened the bathroom door for FC#6 who had asked to use the bathroom; -that night, client #2 was real disruptive and not paying attention to staff; -client #2 and client #3 get along then they don't get along. There was something going on about some clothes; -client #3 suspected client #2 of taking some of his clothes and was mad at client #2; -he went around and entered client #3's room from the commons area to get client #2;	V 314		

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V 314	Continued From page 25 -client #2 was trying to jump on client #3; -not sure if he hit client #3; -did not have to restrain client #2; -client #2 calmed down and went to his room; -client #2 played a lot; -was there when client #2 went into FC#6's room and was "trying to wrestle [FC#6];" -"We(staff) came in there, [client #2] left;" -client #2 likes to horseplay a lot; -"[FC#6] didn't find it too funny;" -"[FC#6] calmed down, they seemed to be ok after that;" -wrestling and horseplay was not allowed; -"Tell them not to horseplay or touch each other because it leads to fights;" -can't remember exactly where client #2 was when he went in FC#6's room; -think client #2 was in the open area(commons area) of unit; -staff rotate rooms to watch; -"We(staff) followed [client #2] into [FC#6's] room." Interview on 9/28/20 with staff #5 revealed: -worked night shift at the facility; -remembered incident between client #2 and client #3; -client #2 and client #3 had been going back and forth. Had to keep the two separated; -client #2 kept trying to get into client #3's room. Client #2 would ask to take trash and staff tell him no; -then client #2 asked to do something else and staff told him no; -he(staff #5) was sitting at client #3's door to prevent client #2 from getting in client #3's room; -staff #4 went into FC#6's room whose bathroom connects to client #3's room and unlocked the bathroom door for FC#6; -staff #4 then came out and was talking to client	V 314		

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V 314	Continued From page 26 #2; -client #2 jumped up, got past staff #4 and ran through the bathroom into client #3's room; -client #2 punched client #3 a "couple of times;" -he(staff #5) got into the room and got them separated with staff #5 assisting; -he walked client #2 back to his room and processed with him and told him his consequences; -client #2 accepted his consequences; -client #2 and client #3 "go back and forth, back and forth, back and forth;" - attack on client #3 "that was uncalled for." Interview on 9/25/20 with staff #2 revealed: -was working during the incident between client #2 and FC#6; -he had gone to take dirty laundry downstairs; -client #2 had behaviors earlier in day. He had just got client #2 calm; -he went downstairs and then came back up and everyone was laughing; -his staff reported client #2 was running around on the unit, jumping on FC#6, just playing; -client #2 also ran into another peer's room; -client #2 was back in his room when he came back upstairs; -"He(client #2) ended up hurting [FC#6] alittle bit;" -when he came back upstairs, he talked to FC#6 and client #2; -FC#6 said he was fine, he just jammed his finger; -talked to client #2, and he said he ran in and jumped on FC#6. Interview on 9/24/20 with client #2 revealed: -"Me and [FC#6] playing, wrestling;" -"[FC#6] put me in headlock;" -"Staff came in, thought we were for real;" -Not allowed to wrestle;	V 314		

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V 314	Continued From page 27 -"Ran in his room and jumped on him (FC#6);" -"he(client #3) made me mad earlier, just ran in his room, started fighting him(client #3)." -staff opened FC#6's bathroom and staff walked away; -"Couldn't catch me, I'm fast;" -FC#6's bathroom connected to client #3's bedroom. -"Staff was right there" -"He (client #3) was laying down saying no, no, no;" -"I got three hits. They(staff) grabbed me." Interview on 9/24/20 with client #3 revealed: -client #2 came from the bathroom; -"ran through other dude's bathroom and tried to fight me." -staff on the unit sitting at the tables; -client #2 punched him 1 or 2 times then staff was there. Observation on 9/24/20 at 10:50am revealed: -the unit had six bedrooms with two beds each with doors open to a square shaped commons area; -the unit had a front stairwell and a back stairwell both leading downstairs; -bedrooms are connected by bathrooms; -the bedroom closest to the back stairwell on the back wall belonged to client #2; -the first bedroom on the right wall closest to the front stairwell belonged to client #3; -the second bedroom on the right wall belonged to FC#6; -tables and chairs were in the middle of the commons area. Review on 9/23/20 and 10/2/20 of client #2's record revealed a monthly treatment plan review/update dated 6/10/20 documented client	V 314		

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V 314	Continued From page 28 #2 ran into a peer's room and tried to fight his peer. Interview on 9/30/20 with FC#4 revealed: -he and client #2 did not get along. Client #2 and FC#7 had stolen some of his belongings; -his father had died, and he got some pictures of his father. He put the pictures on his walls in his room. He was downstairs and client #2 was upstairs. While he was downstairs, client #2 went in his room and tore up his pictures of his father. He was very upset; -couple of nights after that, client #2 ran in his room and punched him while he was sleeping. It woke him up. He heard client #2 saying as he ran out of his room "Ha, Ha, he woke up with his face hurting;" -been in altercations with client #2 in the past. "He was constantly trying to mess with me;" -client #2 thought it was a joke. He came over and smacked FC#4 in the back of the head; -FC#4 did not feel comfortable with client #2 doing that; -"Every day thing for him (client #2). We constantly not get along;" -FC#4 told staff, and they didn't do anything about it; -one time, client #2 started picking on a small kid there, and FC#4 intervened. He and client #2 got into a fight. Client #2 was trying to bully the small kid; -always a fight going on at the facility. Client #2 liked to joke and play. Staff told him to quit it but that was it. Sometimes staff took client #2 upstairs; -"Didn't feel safe there." Interview on 10/1/20 with FC#5 revealed: -remember being at the facility; -there was fighting there;	V 314		

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V 314	Continued From page 29 -got into a fight with 3-4 other peers. They hit each other; -one time he got hit in the face; -a peer hit him in the ear. They were watching TV. Staff was sitting there with them; -staff broke fights up; -staff told kids to stop arguing; -wanted to leave because did not feel safe; -not feel safe because peers were fighting him; -saw other kids fighting there; -saw kids punched in the face by other kids, and saw a kid with a bruise on his face; -don't remember kids' names; -one time, a kid ran into another kid's room and beat that kid up; -"staff were in a crisis." -kid called staff the "n word" and other kid ran in kid's room and beat him up. Interview on 9/30/20 with FC#5's legal guardian revealed: -had a lot of concerns with FC#5's placement there from a parent standpoint; -from the beginning, he was telling her he did not like to be there, -he was crying and not acting normal; -FC#5 said he and a peer got into it and the peer hit him on the side of his head on his ear; -FC#5 was very aggressive while he was there; -always very hyped up and anxious; -FC#5 told her two clients got into a fight; -heard a lot of arguing and cussing going on in the background when she was talking to him on the phone; -moved FC#5 to another same level facility; -he thanked her for getting him out of that facility. He said he was much happier. Interview on 10/2/20 with the Program Director(PD) and the Residential Staff	V 314		

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V 314	Continued From page 30 Supervisor(RS Sup) revealed: -have provided staff with ongoing training on de-escalation, client behaviors, triggers and supervision; -ensured all staff had crisis plans for all clients and were knowledgeable of all clients coping skills and identification of triggers; -already noticed a lot of the issues have been occurring on night shift(6:30pm-6:30am); -had recently hired a team lead for night shift; -not aware of any specific new strategies/interventions developed to address client #2's aggression; -work a lot of overtime to make sure everything ok before they leave the facility; -in process of hiring new staff; -put in place some interventions regarding client #2 such as separating him from clients he was having conflict; -was not aware staff had concerns with sending FC#4 downstairs with client #2 and FC#7 and discussed their concerns. This information was never relayed to the PD and the RS Sup; -plan to address the issues with staff competency, supervision of clients and ensure clients are safe at the facility; -Clinical Director is on vacation and will be involved in addressing issues as well upon her return next week. Review on 10/2/20 of a Plan of Protection dated 10/2/20 completed by the PD revealed the following documented: -"What immediate action will the facility take to ensure the safety of the consumers in your care: A one on one staff will be assigned to [client #2] during shift change and continued until he falls asleep. [Client #2] will have individualized recreation time daily. Clinical team will create PCP(Person Centered Plan) strategies to assist	V 314		

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V 314	Continued From page 31 his impulsiveness on Monday 10/5/20. Increase therapy sessions to 2xs a week for check-ins. Create a Behavior Support Plan by next CFT Mtg (Child and Family Team Meeting);" -"Describe your plans to make sure the above happens: Administration Mtg(Meeting) will occur and brainstorm strategies for all consumers on 10/5/20. Hire additional staff ongoing. Staff supervision will continue monthly to address needs of staff and consumers. 1) request cover of light switches on Thur(Thursday) 9/24/20(pictures sent). Also covered the holes under the outlet as well. 2) Staff mtg today(initial) 10/2/20 to discuss Type A violation-changes being made, being proactive, knowing triggers and coping skills, communication. 3) Created crisis plans with triggers and coping to make sure RC(Residential Counselors)/Staff are familiarize(initially). The crisis plan will change during updated CFT Mtg. 4) Staff Supervisor/Program Director/Clinical Director will randomly check on staff via cameras. This will be placed on log effective today 10/2/20. 5) Placement of staff on the unit to create increased supervision be addressed in night shift effective immediately(zones of supervision)." Client #2 had a diagnosis of Conduct Disorder. FC#4 had diagnoses of Adjustment Disorder with mixed disturbance of emotions and conduct and Reactive Attachment Disorder. FC#7 had diagnoses of Intermittent Explosive Disorder, Attention Deficit Hyperactivity Disorder. Client #2, FC#4 and FC#7 had histories of physical aggression with peers as well as specific conflict with each other. On 6/25/20, Staff #2 and Former Staff(FS) #8 made the decision to allow client #2, FC#4 and FC#7 to be supervised by only one staff(FS#8) despite their prior discussion of	V 314		

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V 314	Continued From page 32 concerns an incident might occur. As a result of their decision, client #2, FC#4 and FC#7 had an opportunity to engage in a physical altercation, and FC#4 sustained a head concussion requiring medical attention. Client #2 had been aggressive towards peers on nine occassions from 6/1/20-9/22/20 resulting in three peers sustaining injuries of cuts, scratches, bruises, jammed finger and swollen jaw. Client #2's goals and strategies in his treatment plan included the reduction and elimination of physically aggressive behaviors and impulsivity. The Qualified Professional/Case Manager was responsible for the development and update/revision of client #2's treatment plan. Client #2's goals and strategies were reviewed eleven times in the past year with no revisions/changes made to the strategies to address client #2's continued significant aggression towards his peers. The lack of staff competency in regards to ensuring client safety from aggressive peers, the failure of the QP/Case Manager to develop/update strategies to address client #2's continued significant aggression towards peers resulting in client injuries and the lack of ensuring client belongings were safe from destruction results in a Type A1 rule violation for serious neglect and harm and must be corrected within 23 days. An administrative penalty of $1,500.00 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 314		
V 541	27F .0104 Client Rights - Stor. & Protect of Cloth/Poss 10A NCAC 27F .0104 STORAGE AND PROTECTION OF CLOTHING AND	V 541		

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	MHL084-085	A. BUILDING: _____ B. WING _____	10/02/2020

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V 541	Continued From page 33 POSSESSIONS Facility employees shall make every effort to protect each client's personal clothing and possessions from theft, damage, destruction, loss, and misplacement. This includes, but is not limited to, assisting the client in developing and maintaining an inventory of clothing and personal possessions if the client or legally responsible person desires. This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure each client's personal clothing and possessions were protected from theft, damage, destruction, loss, and misplacement affecting 1 of 4 former clients (FC#4). The findings are: Review on 9/23/20 of FC#4's record revealed: -admission date of 4/2/20; -discharge date of 7/31/20; -age 14 years; -diagnosis of Adjustment Disorder with mixed disturbance of emotions and conduct and Reactive Attachment Disorder; -treatment plan dated 4/1/20 and updated 7/27/20 documented FC#4 was having difficulties processing his father's passing. On 5/31/20, a letter was found which that eluded to suicide. FC#4 was assessed for suicide by his therapist and placed on suicide watch for 48 hours; -monthly treatment plan review/update on 6/3/20 documented the following incident was discussed: "[FC#4] continues to struggle with his goal to manage his anger. [FC#4] noticed his pictures that were on his wall ripped up by one of his peers. Staff attempted to try to keep him calm, reminding him of his coping skills. He started to	V 541	An updated/revised new client admission personal items checklist (checklist will be included in the facility intake packet) created by the CD will outline what specific items are allowed to be brought to the facility upon admission. Personal belongings will continue to be inventoried upon admission and locked in anoather locate to prevent theft. The LRCS will assign a RC to complete the inventory checklist to ensure nothing not on the list is brought into the facility. (see attached personal items checklist revised)	10/29/2020 & ongoing 10/29/2020 & ongoing

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V 541	Continued From page 34 become more upset and started threatening his peer. [FC#4] began being disrespectful towards staff cursing and calling staff names. [FC#4] started to become more upset and tried to use physical force towards staff and nurse to get peer from his room...[FC#4] came at staff trying to swing his arm which forced staff to use physical intervention..." Interview on 9/25/20 with FC#4's Foster Care Social Worker(FC SW)'s Supervisor revealed: -FC#4's father died and his FC SW made him a picture collage with his father's pictures; -some peers at the facility went in his room and tore up his pictures; -this upset FC#4 very badly; -was concerned about where was staff; -was wondering "where was supervision." Interview on 9/29/20 with FC#4's FC SW revealed: -FC#4's father died; -she had provided him with some pictures of his father; -a peer went in FC#4's room and tore up the pictures. -FC#4 was really upset about it; -she was able to replace the pictures. Interview on 9/30/20 with FC#4 revealed: -client #2 and FC#7 had stolen some of his belongings; -his father had died, and he got some pictures of his father; -he put the pictures on his walls in his room; -he was downstairs and client #2 was upstairs; -while he was downstairs, client #2 went in his room and tore up his pictures of his father; -he was very upset.	V 541		

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V 541	Continued From page 35 This deficiency is cross referenced into 10A NCAC 27G .1901 Residential Treatment Staff Secure for Children and Adolescents-Scope V314 for a Type A1 rule violation and must be corrected within 23 days.	V 541		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on records review, interviews and observation, the facility failed to ensure the facility and its grounds were maintained in a safe, clean, attractive and orderly manner. The findings are: Observation on 9/24/20 at 10:50am revealed: -the unit had six bedrooms with two beds each with doors open to a commons area; -the unit had a front stairwell and a back stairwell; -bedrooms are connected by bathrooms with a total of three bathrooms; -one bedroom was vacant and in the process of being remodeled; -the bedroom closest to the back stairwell had a large hole in the wall beside the bed with patched, unpainted areas on the walls; -half of the wall by the window in the bedroom closest to the back stairwell was covered with some porous board paneling;	V 736	The Facility and Safety Director (FSD) ensured that the large hole in the wall beside the bed with patched, unpainted area on the walls in the bedroom closest to the back stairwell were repaired and painted. The FSD ensured that the large hole in the back wall in the commons area was repaired and painted. The FSD repaired the large hole in the wall under an electical socket by the client bed in the second bedroom on the right. The FSD painted over the patched holes in the bedrooms on the right. The FSD replaced the missing light switch covers in the bedrooms on the left. The FSD painted the areas in the first bedroom to the right. The FSD repaired the hole in the wall going down the back stairwell. Pictures were sent to the surveyor on 9/25/2020 of the light switch covers being in place in the client bedrooms. Pictures were sent to the surveyor on 9/25/2020 of hole in wall under electrical outlet boarded up to prevent access to inside of wall and electrical wiring. The FSD will make repairs in a timely fasion to prevent any safety risks to the facility staff, clients and/or visitors. The FSD will do routine walk throughs of the facility to note any repairs that need to be done and complete or contract out to have the repairs completed in a timely manner.	10/29/2020 10/29/2020 10/29/2020 10/29/2020 10/29/2020 10/29/2020 10/29/2020 9/25/2020 9/25/2020 9/25/2020, 10/29/2020 & ongoing 10/29/2020

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V 736	Continued From page 36 -hole in the back wall in the commons area of the unit; -large hole in the wall under an electrical socket by client bed in the second bedroom on the right; -unpainted, patched holes in the bedrooms on the right; -missing light switch covers in bedrooms on the left; -unpainted areas in the first bedroom to the right; -hole in wall going down the back stair well; -wooden boards over part of the upstairs windows on the outside. Interview on 9/24/20 with client #2 revealed: -been here since November 2019. -boards on the wall stop kids kicking holes; -hole beside his bed been there for 3 days; -he kicked it(the wall); -"[Maintenance] kinda busy. He'll get to it. Kinda my fault;" -no wires inside the wall, just brick on the outside. Interview on 9/24/20 with client #3 revealed: -been at the facility since 8/2020. -have the first room on the right; -have holes in the walls; -holes were there when he was admitted. Interview on 9/24/20 with the Residential Staff Supervisor revealed: -client #2 very destructive in his room and put holes in the walls; -maintenance in the process of remodeling parts of the unit; -some of the bedrooms have been painted recently; -no covers on light switches due to rooms being painted. Review on 9/25/20 of an email sent by the	V 736	The repairs will be completed with 48 hours of being notified by the LRCS, PD or CD of any needed repairs found prior to the FSD's routine walk throughs of the facility, unless it is an emergency (such as a leak, power outage, hole exposing wiring) which could pose a health or safety risk to the facility staff and clients. The FSD will contact other services if the repairs are beyond the FSD's skill set.	10/29/2020 & ongoing 10/29/2020 & ongoing

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V 736	Continued From page 37 Program Director dated 9/25/20 revealed: -pictures of light switch covers installed over light switches in client bedrooms; -pictures of hole in wall under electrical outlet boarded up to prevent access to inside of wall and electrical wiring.	V 736		