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V 000	INITIAL COMMENTS A complaint survey was completed on 12/7/20 (Intake #NC169706). The complaint was unsubstantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents.	V 000	The Governing Body of Solstice East has reviewed the Statement of Deficiencies provided to Solstice East on 12/23/2020 by the Division of Health Service Regulation and submits the following Plan of Correction for identified deficiencies. Each statement of corrective action has been placed herein adjacent to its corresponding tag. Submitted to DHSR on 01/08/2021.	
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement	V 105	V105 - Governing Body: Governing body failed to implement standards of practice that assured compliance with: clients' written discharge, Incident Reporting policies. Solstice East's Governing Body reviewed Tag V105 and gave direction for the following corrections, preventative measures and ongoing monitoring to take place: Correction: Solstice East policies have been reviewed by the Governing Body and updated to align with 10A NCAC 27G .0201 Governing Body Policies. Discharge policy was reviewed by the Governing Body and updated. Clinical in-service held on 12/07/2020 covered Discharge policy and procedures (Refer to V112 Prevention for additional information). Tests were administered to verify proficiency. Residential in-service held on 12/15/2020 included instruction on incident reporting policy and accurate and complete documentation. Behaviors leading to placement on Safety Phase may not require completion of an incident report, and do not automatically include seclusion, isolation time-out or physical restraints, therefore safety phase is not defined as a restrictive intervention. Therapists document Safety Phase in the client's record, and direct care staff will document in the client's shift notes.	

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V 105	Continued From page 1 activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field; This Rule is not met as evidenced by: Based on record reviews and interviews, the	V 105	Continued From page 1 Compliance and Quality Assurance Committee meetings have increased in frequency from quarterly to monthly and review audits conducted within the program that evaluate systems and practices. Tracking, trending and plans to address concerns are reported to the Governing Body after each meeting. The Governing Body has been meeting but not documenting meetings adequately. Meeting minutes will be recorded and maintained permanently. Prevention and Monitoring: Clinical Director, or qualified designee, reviews new Discharge Summaries for compliance with policy. Action plans, to include retraining and/or disciplinary action, will be documented where deficiencies are noted. Program Director, or qualified designee, reviews incidents and associated Incident Reports weekly for completeness and compliance with policy. Action plans, to include retraining and/or disciplinary action, will be documented where deficiencies are noted. Operations Director, or qualified designee, performs weekly secondary audits of client charts and Incident Reports to assess accurate completion of expected documentation. Clinical Director, Primary Therapist and Program Director are informed of deficiencies and corrections are made. A pattern of incomplete documentation will lead to progressive disciplinary action(s), issued by the Clinical Director, Program Director or qualified designee. Discharge planning audits and Incident Report audits will be reviewed by the Governing Body for tracking and trending on a quarterly (or as needed, defined by the governing body) basis. Training and training plans will be created from audits if the need is identified by the Governing Body. The Clinical Director, or qualified designee, will review the use of Safety Phase weekly in Clinical Meetings. Auditing will continue per above plans until substantial compliance is met and maintained as directed by the Governing Body.	

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governing body failed to implement standards of practice that assured compliance with clients' written discharge for 1 of 11 current audited clients (Client #4) and for 4 of 7 former clients (FC #12, FC #13, FC #14, and FC #18). The facility's governing body failed to ensure their reporting incident system was followed to identify trends and patterns for solving problem issues in client care and services for 5 of 11 current clients (Client #3, Client #4, Client #5, Client #8, and Client #9) and for 1 of 7 former audited clients (FC #15). The findings are:

Refer to Tag V112 for additional client information.

Finding #1
Review on 10/9/20 of facility Transfer and Discharge policy updated May 2019 revealed:
"When a client is transferred or discharged from Solstice East, a discharge summary is completed according to the following procedures:
-The primary therapist will complete a written summary of treatment summarizing:
a. The course of treatment while in Solstice East.
b. The clients progress on treatment objectives.
c. The services provided while in program.
d. Problems remaining that still need intervention upon discharge.
e. Recommendations for how ongoing problems should continue to be addressed.
f. The reason for the discharge or transfer.
-The discharge plan will identify resources and services available to the client and family.
-The discharge plan will include aftercare plans set up by family.
-Unplanned discharges will include all of the above as well as:
a. How decision was made for client to

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discharge, including conditions leading to discharge.
b. Whether the discharge was considered Against Medical Advice.
c. Recommendations given to parents regarding the best interest of the child."

Record review on 10/12/20 for Client #4 revealed:
-Admission date - 8/29/19
-Age -16 years,
-Diagnoses: Other Specified Trauma-and Stressor-Related Disorder With Attachment Problems, Other Specified Bipolar and Related Disorder, Other Specified Anxiety Disorder, Other Specified Neurodevelopmental Disorder With Deficits In Visual Spatial Abilities, And Attention-Deficit/Hyperactivity Disorder.
-she was discharged on 10/8/20 with a written discharge report dated 10/9/20 completed by her therapist. Her discharge report did not include:
-summary of her treatment progress;
-indication of the specific services she received from her admission date to discharge date.

Record review on 9/28/20 for Former Client (FC) #12 revealed:
-Admission date-12/20/18
-Discharge date- 3/30/20
-Age-18 years
-Diagnoses- Anxiety Disorder, Depressive Disorder, Attention Deficit Hyperactivity Disorder, Cannabis Use Disorder, Oppositional Defiant Disorder, Conduct Disorder
- discharge report dated 10/8/20 did not include:
-summary of course of treatment;
-progress on treatment goals,
-services provided while in treatment
-identified problems remaining that still needed intervention.

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V 105	Continued From page 4 Record review on 9/28/20 for FC #13 revealed: -Admission date-1/24/19 -Discharge date- 5/12/20 -Age-16 years -Diagnoses- Adjustment Disorder, Parent child relational problem, Learning Disorder Not Otherwise Specified, Cannabis Use Disorder - discharge report dated 5/11/20 signed 7/10/20 did not include: -summary of course of treatment, -progress on treatment goals, -services provided nor problems remaining that still needed intervention. Record review on 9/28/20 for FC #14 revealed: -Admission date- 10/24/18 -Discharge date-4/6/20 -Age-17 years -Diagnoses- Major Depressive Disorder, General Anxiety Disorder, Post Traumatic Stress Disorder, Parent Child Relational Problem, Cannabis Use Disorder - discharge report dated 4/6/20 signed 10/8/20 did not include: -summary of course of treatment, -progress on treatment goals nor services while in treatment. Record review on 10/12/20 for FC #18 revealed: -Admission date- 1/2/20 -Discharge date-10/3/20 -Age-17 years -Diagnoses- Post Traumatic Stress Disorder, Major Depressive Disorder, Generalized Anxiety Disorder, Attention Deficit Hyperactivity Disorder, Specific Learning Disorder, Cannabis Use Disorder, Mood Dysregulation Disorder - discharge report dated 10/3/20 did not include: -summary of course of treatment, -progress on treatment goals	V 105		

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V 105	Continued From page 5 -services provided while in treatment -signature on document. Finding #2 Review on 10/22/20 of Incident Reporting policy dated 5/1/19 revealed: -" ...Procedure for completing a resident involved incident report: A-The employees directly involved with the incident should login to IR (incident reporting) System and complete an incident report. B-Resident Involved incident reports consist of two levels as follows: 1-Level 1 incidents- do not require parental notification include: a-Minor medication errors-missing one dose b-Minor injuries not requiring medical attention or only in-house first aid is required c-Accusations of violations of student rights 2-Level 2 Incidents that do require parental notification include: a-Runaways (AWOL) b-Acts of Physical Violence/fighting c-Injury requiring medical attention d-Any hospitalization (emergency or not) e-Vehicle accident f-Passive physical restraint/Therapeutic Holds g-Medication errors including-wrong med given, more than 1 dose missed h-Substance abuse i-Destruction of property j-Theft k-Sexual acting out l-abuse or neglect m-death n-Violation of the Provider Code of Conduct o-Any other circumstances involving the health, safety or well-being of residents p-Other- there is an 'other' category to use when the specific type of incident is not listed in IR	V 105		

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V 105	Continued From page 6 system. 3-The Employee will complete the Incident Report before the end of their shift and as close to the time of the incident as possible. The report should complete all categories listed in the Incident Report outline. All categories should be specifically completed. 4-Necessary Solstice East Staff members will be notified of the incident based on which type of incident and which level of harm is indicated on the incident report. 5-Staff also will verbally report all incidents to the respective team manager as soon as possible following the incident. The nursing team will be contacted verbally for any incidents involving medication errors and any level of injury or medical related incident. 6-When completing the report, document that the appropriate people were notified including the team manager for the respective team, therapist/clinical director and the nurse in cases of medical or medicine related incidents. 7-When the reports are complete and all necessary follow up is completed and documented the Clinical or Residential Director will close them. 8-The Governing Body reviews incident trends quarterly. If the team decides that there is a need for training, the Executive Director supervises the design and implementation of that training in conjunction with the Team Manager. Reports of corrections in trends should document both the suggested intervention and the implementation of the intervention ..." Review on 10/29/20 of email from the Operations Director dated 10/29/20 regarding the facility's Governing Body revealed: -"Our Governing Body is made up of [our Executive Director] and the [Clinical Director] with	V 105		

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support from [an owner] and the [Operations Director]. Our policies state that the Governing Body is required to meet at a minimum of every 6 months, but because members are also active Directors, they are meeting very regularly, sometimes weekly to discuss future planning, policy changes and staffing. The documentation of notes in these meetings has not been as formal as the documentation for the weekly Leadership meetings, which Governing Body members are a part of and where incident reports are a topic of review ..."

Review on 10/29/20 of Governing Body meeting minutes between March 2020 and October 2020 revealed:
-4/14/20- "IR [incident report] reports- Debrief about incident in the pond, should we create a policy, flotation device (emergency kit nearby), call 911, committee including [staff] - what do you do if a kid is a danger to themselves in water, tree, high places, flow chart."
-8/26/20- "IR reports- No IRs from yesterday Schedule debriefs."
-"IR REPORTS/DRILLS" appeared as a routine category in the minutes but did not include any data regarding trends.
-No evidence was presented of governing body, leadership or treatment teams reviewing incident report trends or completeness of any incident reporting.

Review on 9/27/20 of facility incident reports 3/28/20-10/23/20 revealed:
-115 medication errors indicating a pattern which was not addressed.
-21 restrictive interventions utilized over a total of 10 clients, indicating a trend that was not addressed. Additionally, medical records for sampled clients reflected a use of the safety

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V 105	Continued From page 8 phase. However, safety phase was not identified as a restrictive intervention by the facility and was not included on the facility's incident reports. Therefore, the full extent of the use of restrictive interventions by the facility was unable to be determined. Interview on 12/1/20 with management staff who included the Founder, Executive Director (ED), Operations Director, Clinical Director, and Program Director revealed: - indicated they had reviewed their written policies and had already implemented some changes in their practices. This deficiency is cross referenced into 10A NCAC 27E .0101 Least Restrictive Alternative (V513) for a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 105		
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	V 112	V112 - Treatment Plan: Facility failed to develop and implement treatment strategies. Solstice East's Governing Body reviewed Tag V112 and gave direction for the following corrections, prevention measures and ongoing monitoring to take place: Correction: Master Treatment Plans were corrected to address deficiencies by client's primary therapist on, or before, 12/30/20. Updates to sections 2.2 and 2.3 in the SE P&P focused on Treatment Planning and Transfer and Discharge have been made to align with 10A NCAC 27G .0205. Clinicians will complete expected documentation weekly. Clinical Director, or qualified designee, will monitor completion of required documentation weekly.	

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V 112	Continued From page 9 responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to develop and implement treatment strategies for 7 of 11 current audited clients (Client #2, Client #3, Client #4, Client #5, Client #6, Client #8, and Client #10) and 2 of 7 former audited clients (FC #12 and FC #14). The facility failed to ensure each treatment plan was developed with the client's legally responsible person for 5 of 11 current audited clients (Client #2, Client #3, Client #4, Client #5, and Client #6) and for 6 of 7 former audited clients (FC #12, #13, #14, #15, #16, #18). The findings are: Refer to V521 and V522 for additional client information on restrictive interventions. Review on 10/9/20 of the facility's written Safety Phase policy 4.3 and dated August 2018 revealed: -Safety phase was an intervention designed for clients who demonstrated behaviors that were deemed by the facility to be physically and emotionally unsafe for all clients and staff and	V 112	Continued From page 9 Clinical Director, or qualified designee, will review newly created master treatment plans for inclusion of diagnosis; goals, objectives & interventions specific to diagnosis; and incorporation of recommendations noted on psychological exams. Before signing treatment plans, Clinical Director, or qualified designee, will review for deficiencies, then correct and retrain specific clinician should any be identified. IT added items to BlueStep MTP, Discharge Summary and Team Meeting forms to align with requirements in 10A NCAC 27G .0205. Prevention and Monitoring: Clinical in-service held on 12/07/2020 covered the following items. Tests were administered to verify proficiency. 1. Master Treatment Plan and Discharge Summary policies, including, but not limited to: a. Requirement for input and involvement of client or legally responsible party as documented by obtaining signatures. b. Problem area, goals, objectives and strategies associated with each diagnosis. i. Focus on client-centered design of strategies. ii. End dates vs. Target dates c. Persons responsible. d. Inclusion of interventions pertaining to: i. Restrictive interventions in the case of repeated instances of emergency RIs. ii. EP, Safety, Self-Harm, SI, Run Risk, Impulse Control, etc. e. Incorporation of data from outside assessments (e.g., psychological evaluations). f. Addressing differences in clinical opinions related to diagnoses in prior assessments. g. Deadlines for completion. 2. Policies surrounding documentation of RIs or other incidents, and notification to parents and appropriate notification of resident's team. 3. Completion of section "individual strategies" in Biopsychosocial Assessment. 4. Procedure for filing of assessment-related records. 5. Location of psychological evaluations, provider releases, and other clinical documentation.	

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V 112	Continued From page 10 included but were not limited to: -any act of violence towards another person; -any threat or implied threat of violence, verbal or physical; -sexual acting out (kissing, touching another person, inappropriate conversations, sexual jokes). -A therapist or licensed therapist authorized the approval for a client to be placed on Safety. -Staff were responsible to inform the client of the placement on Safety Phase and educate about the consequences, limitations and expectations. -This phase had a time range that client restrictions lasted from 18 to 72 hours. If an extension was needed, a client's therapist was required to document clinical justification for the extension in the client's case notes. -A client was kept in staff sight by being placed at arm's length with staff for the duration a client was on safety phase. -During the night shift, a client might be required to sleep on their mattress in the hallway or in the den (common area) to be maintained in staff sight. -A client on Safety was expected to complete all requirements of the phase to be returned to their previous treatment phase. -Expectations of the Safety phase included not were not limited to: -completion of a written safety phase assignment focused on understanding the impact of their behavior on others; -completion of written apologies to those affected by their unsafe behavior(s); -presentation of an oral report to their team on the principles related to the safety (behavior) code they violated; -completion of a service project related to the safety code they violated; -presentation of their safety phase assignment	V 112	Continued From page 10 Clinical Director, or qualified designee, performs weekly audit of client charts to assess accuracy and timeliness of documentation related to interventions, safety strategies, and use of least restrictive interventions (including continuation or discontinuation of RIs). Clinical Director, or qualified designee, sends calendar invite to client's primary therapist with a reminder prior to MTP due date. Clinical Director, or qualified designee, will review new MTP's for compliance with policy. Action plans, to include retraining and/or disciplinary action, will be documented where deficiencies are noted. Clinical Director, or qualified designee, sends calendar invite to client's primary therapist upon confirmation of client discharge date which includes reminder to complete Discharge Summary prior to discharge. Clinical Director, or qualified designee, will review new Discharge Summaries for compliance with policy. Action plans, to include retraining and/or disciplinary action, will be documented where deficiencies are noted. Operations Director, or qualified designee, performs weekly secondary audits of client charts to assess completion of expected documentation. Clinical Director and Primary Therapist are informed of deficiencies and corrections are made. A pattern of incomplete documentation will lead to progressive disciplinary action(s), issued by the Clinical Director, or qualified designee. Auditing will continue per above plans until substantial compliance is met and maintained as directed by the Governing Body.	

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V 112	Continued From page 11 to a resident (peer) safety council where they were required to report what they have learned from the experience being on safety and seek feedback from the safety council. -The council was expected to give feedback to the client's treatment team about whether the client completed their assignments and was ready to return to their phase or needed to remain on their Safety Phase; -A treatment team made a final determination whether a client returned to their previous phase or was stepped down in their treatment phase. Review on 10/9/20 of written descriptions of critical interventions in the facility's student handbook revealed: -the Safety Phase (see above). -Self-Focus was an intervention designed to be imposed on clients to increase their compliance with facility rules and codes of conduct. The intervention included but was not limited to: -a client being required to spend her unit activities, treatment phase activities and free time in the completion of assigned work by her therapist or member of a clinical team; -suspension of her phase privileges on any given treatment phase until her Self-Focus time ended; -privileges during this time being determined by her treatment team; The period of Self-Focus was not to last longer than 72 hours unless clinically indicated. Record review on 10/5/20 for Client #2 revealed: -Admission date-5/13/19 -Age-16 years -Diagnoses-Unspecified Anxiety Disorder, Major Depressive Disorder, Disruption of Family By Separation Or Divorce, and Parent-Child Relational Problem	V 112		

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V 112	Continued From page 12 -Behavior-Struggled with managing episodes of anxiety. -Her treatment plan dated 5/19/20 did not include: -staff or position(s) responsible for the services to be provided to her (Behavior Coaching-as needed, 24-hour on-call crisis services-ongoing, Case Management-Ongoing, Affective Education-Ongoing, 24-Hour monitoring by "counseling staff" ongoing, Individual Therapy -1 time a week, Group Therapy-3 times a week); -documentation her guardians participated in, were sent an updated copy of her plan or returned her plan with an indication they agreed with her plan. -Client #2 signed her updated plan on 9/24/20. -Client #2's 5/19/20 plan was signed by her therapist on 5/19/20 and the Clinical Director on 9/26/20. Attempted interview on 11/9/20 with Client #2's guardian revealed: -no response from a voice mail message left requesting a return call. Record review on 10/12/20 for Client #3 revealed: -Admission date-5/11/20 -Age-15 years -Diagnoses- Major Depressive Disorder, Attention-Deficit Hyperactivity Disorder (ADHD) Generalized Anxiety Disorder (GAD) -Behaviors- Presented at admission with suicidal ideation with no plan but wanted to leave. Histories of 3 suicide attempts and specific self-injurious behavior, had bouts of crying, felt depressed and hopeless, anxiety(worried about whether people liked her, excessive worry and irritability), had panic attack at times, and arousal over traumatic events. -Her treatment plan dated 6/18/20 did not include: -a goal with treatment strategies that addressed	V 112		

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her urges to elope from the facility;
-strategies that were developed to address her goals around managing her depression while helping her to maintain safe behaviors and alleviating her suicidal impulses;
-documentation of a crisis plan with possible use of strategies to address her behaviors during crisis situations.
-an updated plan with goals and treatment strategies from her written psychological evaluation dated 6/18/20 that included:
-helping her learn and understand her diagnoses
-communicate her feelings openly
-having those close to her (caregivers) provide her with evidence (examples) of accomplishments (successes) when she expressed feelings of failure
-developing a daily program of physical activity
-providing a positive and supportive environment rather than a punitive atmosphere.

Review on 10/12/20 of individual therapy note entries for Client #3 revealed:
-on 6/23/20, Client #3 reported she self-harmed during the previous weekend. Her written safety plan was reviewed and discussed with her by her therapist;
-on 9/1/20, a "crisis intervention note" indicated she reported to a clinical team member she had self-harmed and had urges to run;
-she had a suicide risk assessment completed and a plan to be reassessed in 48 hours;
-she was placed on safety precautions;
-the type of precautions she was placed on were not identified.
-on 9/4/20 (3 days later) and on 9/7/20, 2 entries titled "crisis intervention note" indicated she was assessed for safety and run risk;
- No documented changes were indicated

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V 112	Continued From page 14 about her safety precautions and a determination made whether she was removed from her safety precautions; -on 9/8/20, she attempted to elope from the facility. She walked back inside the facility and "staff did not have to go hands on.." Review on 11/23/20 of a printed staff shift note about Client #3 revealed: -the shift note included Staff #34's name at the top of the note; -Staff #34 was a Team Manager; -9/1/20, Client #3 was identified as placed on "full" safety precautions and run risk; -her safety precautions included "snaps and sweeps" (a client was required to snap their bra and underwear for any possible contraband to fall out and sweep a certain room to remove any objects which a client could use to self-harm), "cracked and counting" (a client was required to keep the bathroom door cracked open and count to maintain communication with staff to ensure safety), wear slides/flip flops, remain arm's length of staff. -9/3/20, she was taken off safety precautions and continued on run risk precautions, which included her need to continue to rate her run urges every hour and implement her "grounding/regulating skills;" -9/8/20, she was placed on Safety Phase and "contained" to the facility; -9/12/20, she was removed from Safety Phase but continued on run risk and additional safety precautions; -9/17/20, her run risk and safety precautions were modified by her therapist; -9/22/20, she was removed from all her safety precautions and had her phase privileges restored.	V 112		

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V 112	Continued From page 15 Review on 10/12/20 of a treatment plan review report dated 7/28/20 of Client #3's 5/18/20 plan revealed: -the report, which had a begin and end review date of 7/28/20,was signed by Client #3's therapist and the Clinical Director on 9/25/20; -she struggled to integrate interventions (knowledge and skills) she learned in her therapy into her daily life and her relationships with peers; -she continued to struggle with urges to self-harm and had a plan to self-harm using a 2-component hook-and-loop fastener, which led to her "restriction of phase privileges" for 72 hours. During this time, she completed an hourly suicide risk assessment with staff; -there were no indicated changes made to her treatment plan as a result of this clinical review. Interview on 11/2/20 with Client #3 revealed: -she was on the 3rd treatment phase (Orientation Phase was included as the 1st phase) when she was placed on Safety Phase for 5 days; -she went before a resident (peer) safety council before she came off this phase, and then was placed on safety precautions for 1 week; -she lost privileges with her 3rd treatment phase while on Safety which included no telephone calls with her parents, no makeup or jewelry, no listening to music, no going outside or participation in group activities (she observed group activities inside the facility) and slept in the common area; -she saw her therapist once during this time. Record review on 10/12/20 for Client #4 revealed: -Admission date-8/29/19 -Discharge date-10/8/20 -Age-16 years -Diagnoses-Other Specified Trauma-and Stressor-Related Disorder With Attachment	V 112		

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V 112	Continued From page 16 Problems, Other Specified Bipolar and Related Disorder; Other Specified Anxiety Disorder; Other Specified Neurodevelopmental Disorder, and Attention-Deficit/Hyperactivity Disorder (ADHD) -Behaviors- History of physical self-harm and a suicide attempt, struggled with anxiety and depression -Her 3/23/20 treatment plan did not include: -strategies that were developed to address her goals of reducing her depression symptoms, how she would identify individuals from whom to gain support and/or learn and use coping or safety methods when safety concerns arose (prevent urges to self-harm), and how she would increase her emotional vocabulary to communicate her feelings with others; -documentation of the treatment programs and/or services, including staff names and/or positions responsible for the services provided to her during her admission; -documentation of a crisis plan with possible use of safety strategies to address her behaviors during crisis situations. -a guardian signature or documentation that indicated whether she and/or her guardian participated in, reviewed and/or agreed to her treatment plan. -Her treatment plan was signed by her therapist on 3/23/20. Review on 10/15/20 of 3 incident reports for Client #4 revealed: -6/7/20, she was observed by Staff #11 and Staff #12 going into her room "less than a minute" after a stressful experience with her peers. When she came out of her room, she told these 2 staff she drank 4 large gulps of shampoo; -a recommendation was made she be taken to a local hospital in the event she had ingested something else in addition to shampoo after Staff	V 112		

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V 112	Continued From page 17 #12 notified a medical nurse on-call and a poison control agency; -there was no documentation that indicated she had a local hospital visit. Her vital signs were checked twice by Staff #12 and were noted to be normal. She was placed on safety precautions. -7/29/20, she attempted to self-harm while on a safety precaution (she was placed on-arms staff supervision) with Staff #11. During this process, she picked up an alcohol-free, non-toxic mouthwash from the bathroom counter and drank "multiple swigs" of this substance; -she refused to cooperate with Staff #11's direction to drink water; -the team manager and a poison control agency were notified by Staff #11 but no specific information or instructions were documented as a result of these notifications; -she refused to answer questions to a suicide risk assessment. -7/30/20, she walked up from the basement of the facility to her bedroom at 11:43 pm, barricaded herself in her bathroom, threatened to drink shampoo, was placed in a "team wrist" hold that lasted 5 minutes with a begin time of 4:00 and an end time of 4:05; -she was placed in a hold by an unnamed staff after she began banging her head; -she returned to the basement and banged her head against the wall and unnamed staff "went hands on" with her; -she returned to the bathroom, returned to banging her head against the wall and an unnamed staff "went hands on again" with her. Review on 10/15/20 of Individual Therapy note entries for Client #4 revealed: -7/20/20, she processed the reporting of a traumatic event that occurred in another state; -7/29/20 was her next therapy session in which	V 112		

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she showed regressed behavior (refused to accept feedback or answer questions from her therapist);
-7/30/20, a "crisis intervention" note, which indicated "[Client #4] began on days prior to become unresponsive and say she doesn't care anymore. Then began to be verbally aggressive, refusing water or food ...Continued to be come more intense and then placed in safety room with 1-2 staff. Was resistant to doing work to come off the safety phase."
-This note continued that on 8/2/20, her vital signs "deteriorated" and she was transported to the hospital where as of 8/4/20, she remained;
-8/11/20, she met with her therapist upon her return from the hospital, and was assessed for suicidal ideation and feelings around her return to the program, as well as, when she would return to the milieu after quarantine;
-8/20/20, she expressed her refusal to eat and drink was a way of her control due to not having been able to return home on an authorized leave;
-Due to a failure to accurately document her Safety Phase(s), it could not be determined when Client #4 was placed on and removed from Safety Phase and/or safety precautions during her admission.

Review on 10/20/20 of 2 printed emails from a team manager (Staff #27) sent to two named group staffs about Client #4 revealed:
-The 1st email was dated 7/31/20, sent at 1:06 AM, and notified staff that she was moved away from her peer team and into the facility basement due to her behavior and safety needs for self and others;
-She remained on Safety and "clear boundaries and outcomes were set," in that she understood if she got off the couch without communicating, staff would "go hands on" because she could not

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be trusted to not self-harm.
-The 2nd email was dated 8/2/20, sent at 5:56 PM, and notified staff she was transported to a local hospital due to continued refusal to eat or drink.

Review on 10/12/20 of 2 written clinical reviews of Client #4's 3/23/20 treatment plan revealed:
-the 1st review occurred on 6/10/20 and the 2nd review was on 9/21/20;
-both the reviews (6/10/20 and 9/21/20) lacked documentation that the client and/or guardian participated in the reviews, which had client rights restriction marked "yes;"
-there was no additional information in either review that indicated what her restrictions were but indicated her continued refusal behavior to follow expectations and/or directions;
-there were no indicated changes made to her treatment plan as a result of this clinical review.
-These reviews were signed by her therapist on 9/21/20 and signed by the Clinical Director on 9/23/20.

Interview on 11/3/20 with Client #4's relative revealed:
-her guardian refused to be interviewed and was aware of the guardian's refusal for Client #4 to be interviewed.
-Client #4 graduated from the facility and was 3 weeks into her new program where she struggled with the same issues she did at the facility, which included asking why nobody liked her. The relative questioned why Client #4 was not using her coping skills she learned at the facility and expressed hope the skills Client #4 had learned at the facility would have stuck as she adjusted to her new program.

Record review on 10/12/20 for Client #5 revealed:

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V 112	Continued From page 20 -Admission date-4/9/20 -Age-17 years -Diagnoses- Post-traumatic Stress Disorder, Major Depressive Disorder, Substance Abuse Disorder-Severe, Parent-Child Relational Problem, and Personal History of Childhood Physical Abuse -Behaviors-Struggled with "Extreme" anxiety and elopement -Her 5/8/20 treatment plan did not include: -strategies that were developed to address her not running from the facility and helping her learn coping skills to use in situations that managed her increased anxiety; -identified staff or positions responsible for the services (24-hour monitoring by "counseling staff" as needed, 24-hour on-call crisis services, Family Therapy) that were provided to her; -documentation of a crisis plan with possible use of safety strategies to address her behaviors during crisis situations. -There was no guardian signature or documentation that indicated the guardian's participation in, review of or agreement to her plan. -Client #5 signed her treatment plan on 9/28/20 with her therapist's signature on 5/8/20 and the Clinical Director's signature on 9/26/20. Review on 10/12/20 of facility incident reports made available for review for Client #5 revealed: -the incident reports ranged in date from 4/11/20 to 8/25/20; -she had 6 documented incidents of attempted elopements from the facility (4/11/20, twice on 4/14/20, 5/3/20, 8/10/20 and 8/25/20); -in each of these incidents, she was placed in restrictive interventions that included occurrences of physical holds and isolated time-outs ; -4 of the above incidents occurred prior to her	V 112		

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V 112	Continued From page 21 5/8/20 treatment plan; -8/25/20 incident report revealed: -her elopement attempt had escalated when she walked off from her assigned location at school without anyone having noticed and she made her way onto the roof of one of the facility buildings where Counselor #1 and Counselor #3 unsuccessfully attempted to talk her down from the roof; -When local first responders (fire department and law enforcement) arrived to assist with this situation, she jumped to the lower part of the roof and was caught by Counselor #1 before she rolled completely off the roof. She was placed on the ground, restrained by local law enforcement and transported to a local hospital where she was treated for a left sprained ankle. Review on 10/12/20 of Individual Therapy notes for Client #5 revealed: -6/15/20, a "crisis intervention note," which indicated she was placed on Safety Phase and Run Risk due to her having ran off the property. No additional information was provided. -From 7/22/20 to 8/12/20 (3 weeks), there was no documentation in her record that indicated she had individual therapy sessions with her therapist during this period of time. -8/25/20, a "crisis intervention note," which described Client #5 on the roof of a facility building and her refusal to comply with her therapist's attempts to get her to come down; -she appeared "panicked" as observed by her therapist when local law enforcement arrived on the scene, and eventually jumped from her location; -she was restrained and transported to a local hospital to be medically evaluated; -8/26/20, she was placed on Safety Phase when she returned from the hospital;	V 112		

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V 112	Continued From page 22 -8/27/20, she was removed from Safety Phase and placed on "Self-Focused" (an intervention approved by a therapist for up to 72 hours and limits a client's activities and free time in order to complete assigned work provided by the therapist. Any privileges a client had in their treatment phase while on Self-Focus is suspended until the intervention ends as determined by the client's treatment team); -8/31/20, she was removed from Self-Focus and returned to her normal treatment phase. Review of a printed email from Staff #34 dated 6/15/20 and sent to four named group staff at 9:39 PM revealed: -Client #5 was placed on Safety Phase and Run Risk on 6/15/20. Review of a printed email from Counselor #3 dated 6/16/20 at 8:11 PM and sent to 3 named group staff revealed: -Client #5 was removed from Safety and Run Risk and placed back on her treatment phase with all her privileges. Review on 11/23/20 of 2 printed shift notes with a date range from 7/8/20 to 8/29/20 revealed: -Both shift notes included Staff #34's name at the top of each note; -7/22/20,Client #5 was on Safety Phase and removed from Safety on 7/23/20; -8/24/20, she was off Safety and on Self-Focus which included her remaining 10-feet from her team, being within "eyes" of staff, self-focused on her assignments, and complying with her intervention expectations. Interview on 11/9/20 with Client #5's guardian revealed: -client's plan was emailed to her for review and	V 112		

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she had an opportunity in the family therapy sessions to ask questions;
-anything the facility emailed to her for signature, she signed and emailed back.
-the only time she indicated Client #5 was placed on safety was when she was transported to the facility and she needed to be kept safe.

Record review on 10/13/20 for Client #6 revealed:
-Admission date-3/25/20
-Age-15 years
-Diagnoses-Parent Child Relational Problem, And Other Specified Trauma-And Stressor-Related Disorder
-Behaviors-parent-child relationship attachment difficulties
-Her 3/25/20 treatment plan did not include:
-strategies that were developed to address her goals to work through (past) abuse issues, increase her ability to communicate assertively with her parents, and help her establish and maintain a healthy bond with her primary caregivers;
-programs and/or services, including staff names and/or positions responsible for the services provided to her during her admission;
-a guardian signature or documentation that indicated the guardian's participation in or agreement to her treatment plan.

Interview on 11/9/20 with Client #6's guardian revealed:
-she spoke with the therapist about Client #6's plan;
-she may have signed her plan but she did not remember signing the plan.

Interview on 9/29/20 with the facility Operations Director revealed:
-Client #6's plan appeared not to have a signature

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V 112	Continued From page 24 page in the electronic system with her guardian's signature. Record review on 10/14/20 for Client #7 revealed: -Admission date-6/28/19 -Age-18 years on 9/16/20 -Diagnoses- Persistent Depressive Disorder, ADHD, Gender Dysphoria in Children, Parent-Child Relational Problem, GAD, History of Child Sexual Abuse -Behaviors- Depressed, Hearing voices, physical and verbal aggression toward family, self-injurious behavior -Her 3/15/20 treatment plan did not include: -strategies that addressed her goals to: take her medications as prescribed, sustain her attention and concentration, improve her impulse control and her frequency of on-task behaviors, as well as, demonstrate an improved self-worth and an improved distress tolerance, and an improved ability to cope with difficult and overwhelming emotions; -her guardian's signature or documentation that indicated her and/or her guardian's participation in or agreement with her plan. -There was an end date of 9/24/20 on her plan, which not signed until 9/24/20 by Client #7's guardian. Review on 10/14/20 of individual therapy notes for Client #7 revealed: -6/29/20, her therapist attempted to discuss the results of a recent psychological test and need to change her treatment plan; -7/9/20 and 7/14/20, her therapist continued attempts to discuss her new diagnosis of ADHD and removal of Autism diagnosis with need to change her plan; -Client #7 remained argumentative and resistant to new diagnosis and treatment plan.	V 112		

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V 112	Continued From page 25 Review on 10/14/20 of family therapy notes for Client #7 revealed: -6/25/20, her therapist reviewed the results of her recent psychological test with her and her guardians; 7/16/20, psychoeducation began with Client #7 and her guardian about ADHD and Borderline Personality Traits. Interview on 9/24/20 with Client #7 revealed: -she had never been restrained or placed on Safety Phase since she was admitted; -she indicated no issues related to her treatment plan. Record review on 10/22/20 for Client #8 revealed: -Admission date-10/31/19 -Age-16 years -Diagnoses-Unspecified Trauma-and Stressor-Related Disorder, Adjustment Disorder, Unspecified, Oppositional Defiant Disorder (ODD), Major Depressive Disorder, Parent-Child Relational problem, and Cannabis Use Disorder -Behaviors-Struggled with lying, manipulative behaviors, defiance, blaming others and a lack of accountability for her own behaviors, as well as, lack of emotional coping skills that result in depressive symptoms -Her 3/13/20 treatment plan did not include: -strategies that addressed her goals to: identify and use 3 coping skills when she felt emotionally distressed, learn and use 3 calming skills to reduce and manage her anxiety symptoms, build self-esteem and sense of empowerment, understand appropriate behaviors and boundaries (under problem area of sexualized behaviors), identify and use ways to elicit positive attention, and to learn assertive skills to reduce her angry feelings and solve problems;	V 112		

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V 112	Continued From page 26 -the staff or position responsible for the services (24-Hour monitoring by "counseling" staff-as needed, Individual Therapy-1 time a week, Group Therapy- 3 times a week, 24-hour on-call crisis services- as needed) provided to her during her admission; -documentation of a crisis plan with possible use of safety strategies to address her behaviors during crisis situations. -her guardian's signature or documentation that indicated her and/or her guardian's participation in or agreement with her plan. -Her treatment plan included: -a 4/2/20 written entry by her therapist that she was placed on Safety Phase (an intervention phase authorized by a therapist with a client who had behavior(s) which was/were deemed safety violation(s) by the facility and followed by requirements a client had to complete to be removed from the phase) for sexualized behavior with a peer; -a 6/2/20 written entry by her therapist that she explained to Client #8 why she was on the Safety Phase and how her actions kept her on this phase "longer than necessary." This entry lacked documentation that indicated a reason for the extension of Client #8's Safety's Phase. Review on 11/7/20 of individual therapy notes for Client #8 for the period from 4/1/20 to 10/6/20 revealed: -a lack of documentation that made it difficult to determine a reason for her extension on Safety Phase and the duration she was on this phase from 4/2/20. -8/24/20 "crisis intervention" note entry indicated she was placed on Safety Phase after staff (unnamed) learned she lied and manipulated unnamed staff and was physically "inappropriate" with "multiple" clients;	V 112		

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-8/28/20 "crisis intervention" note entry indicated she remained on Safety Phase due to "little to no remorse or accountability for her actions;"
-8/29/20 "crisis intervention" note entry indicated she was taken to a local hospital for a medical evaluation after she self-reported she ate 2 clothes detergent pods from the laundry room. Once she returned from the hospital, she was placed on "full" Safety precautions;
-8/31/20 individual psychotherapy note indicated she was removed from her Safety Phase and stepped down in her treatment to the 1st treatment phase (Orientation);
-Due to a lack of documentation on her crisis intervention notes, it could not be determined who authorized her Safety Phase and safety precautions. There was not a staff name or position related to each of these notes in her record.

Review on 10/22/20 of a written psychological evaluation dated 9/11/20 for Client #8 revealed:
-3 additional diagnoses- Adjustment Disorder, Major Depressive Disorder, and Cannabis Use Disorder;
-these diagnoses were added into her 3/13/20 treatment plan without an updated plan completed that included treatment goals and strategies from the 22 recommendations made.
-the 1st specific recommendation was "[Client #8] must be continually monitored regarding the severity of her suicidal thoughts and self-harm behaviors, and a safety plan must address possible concerns;"
-additional recommendations included: #11- she may benefit from relaxation strategies, mindfulness, guided exposure and healthy lifestyle management to handle stressful situations, #12- learn and understand her diagnoses along with the patterns of her

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behavior, and #16-maintain positive relationships and a supportive environment to increase her interpersonal skills.

Review on 11/23/20 of a printed staff shift note that ranged in date from 7/23/20 to 9/15/20 revealed:
-The note had a Team Manager's name (Staff #34) on top of the note;
-8/24/20, Client #8 was on Safety Phase;
-9/3/20, she had moved from the initial phase of Orientation to the phase of Separation but continued to be on safety precautions, which included snaps and sweeps (student was required to pull or snap their bra and underwear for any possible contraband to fall out and a sweep of client area was removing objects with which they could self-harm) and was required to sleep in the common area through 9/15/20.

Review on 10/23/20 of a hospital discharge summary dated 8/29/20 for Client #8 revealed:
-there was no documentation that indicated she spoke with her guardian during her hospital visit;
-documentation by the attending hospital physician indicated communication occurred with Client #8 and facility staff with instructions for her to follow up with her behavioral health team on 8/31/20 "first thing Monday morning."

Interview on 11/3/20 with Client #8 revealed:
-she had been in treatment for a year;
-she had reached the next to last treatment phase when she had to restart her program-she was phased down by her therapist after she was placed on Safety Phase upon her return from a hospital visit;
-she initially indicated her hospital emergency room visit could have resulted from a medication side effect (she had started a new medication for

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depression and anxiety before her home visit) or her behaviors while she was on a home visit;
-she later explained she went to the hospital after she and peer who included Client #19 were on Safety and were "roasted" (3 peers were allowed to "interrogate" with questions in front of the team and talk "s**t about you" in front of the team);
-at the hospital, she asked to talk to her family and was told to wait until Monday morning when she had a family therapy session;
-her family therapy session did not occur the following Monday, 8/31/20;
-her therapist met with her Monday afternoon and phased her down to restart the program.

Record Review on 10/15/20 for Client #9 revealed:
-Admission date-3/16/20
-Age-16 years
-Diagnoses- Major Depressive Disorder, Anxiety Disorder, Personal History of Self-Harm, ADHD, Unspecified Trauma-and-Stressor Related Disorder
-Behaviors-Struggled with depression, feelings of physical aggression toward self and others, problems with attention and ability to concentrate on tasks, history of suicide attempts
-Her 4/18/20 treatment plan did not include:
-strategies that addressed her goals which included: identify and manage her emotions in a safe and effective manner, improve distress tolerance and ability to cope with difficult and overwhelming emotions, an improved ability to manage negative thoughts and feelings, develop healthy cognitive patterns and beliefs about self and the world, and reduce her overall frequency, intensity, and duration of anxiety episodes to improve daily functioning;
-strategies that addressed her behaviors related to suicide/self-harm urges and elopement;

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V 112	Continued From page 30 -a 24-hour crisis service identified as available to her during crisis situations; -documentation of a crisis plan with possible use of safety strategies to address her behaviors during crisis situations. Review on 10/15/20 of a written incident report dated 4/25/20 for Client #9 revealed: -she began her morning with refusing to get out of bed. She remained at the facility with staff and told Staff #8 and Staff #12 she felt unsafe and looked for an opportunity to run; -these staff "determined" she needed to be moved to a "safer location" and placed Client #9 into a "transport hold" (a restrictive intervention) and moved her into a specific group room in the facility where she and staff were the only individuals present. She was "eventually" returned "back upstairs" with her team. -Due to a lack of documentation in the incident report, the duration of Client #9's restriction to the group room could not be determined. Review on 10/15/20 of individual therapy notes for Client #9 revealed: -4/16/20, a note titled "other" indicated she was placed on Safety precautions due to her "continued threats" of self-harm, suicide, and elopement. She presented with these behaviors to gain notice from staff in competition with other clients that were struggling with safety issues. Attempts were made to place her with a staff. When placed on "full" Safety precautions, she responded with anger and resentment over "adjusted" privileges; -5/13/20, individual psychotherapy note indicated she was placed on Safety Phase by her therapist due to self-harm and threats of elopement; -6/16/20, a "crisis intervention" note indicated that she was placed on Safety Phase until a further	V 112		

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assessment was completed. She reported to an unnamed staff "high urges" for suicide and self-harm. She reported she collected sharps and hid them in her personal belongings. Staff (unnamed) completed a Suicide Risk Assessment with Client #9 and her score was "high;"
-6/19/20, a "crisis intervention" note that she has "continued to collect small items that could be used as cutting devices and continues to report high urges for self-harm and suicide." There was no documentation that addressed immediate safety measures for Client #9.
-6/22/20, a "crisis intervention" note indicated that she had completed her safety assignments and appeared stabilized with the plan to return to "normal" supervision the next day;
Due to a lack of documentation, it was difficult to determine what staff authorized Client #9's Safety interventions, the duration of the safety interventions, and what staff entered the crisis intervention notes into her record.

Interview on 11/3/20 with Client #9 revealed:
-she had been on Safety Phase twice since her admission and Safety was a "consequence" to keep her safe. She had also been physically restrained once or twice when she attempted to run away.
-she was placed on Safety because she tried to run away and tried to harm herself.
-she did not indicate how long her Safety Phases lasted.
-Once while on Safety, she was placed in a room instead of in the basement because there was someone in quarantine in the basement at the time.

Record review on 10/16/20 for Client #10 revealed:

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V 112	Continued From page 32 -Admission date-6/8/20 -Age 17 years -Diagnoses-Other Specified Trauma-and Stressor-Related Disorder, Parent-Child Relational Problem, and ADHD -Behaviors-History of an abusive intimate relationship, history of substance abuse, struggled with anger by lying, yelling and self-isolating -Her 7/3/20 treatment plan did not include: -staff or position(s) responsible for the services (Case Management-ongoing, Behavior Coaching-ongoing, 24- on-call crisis services-ongoing, Family Therapy-ongoing, Individual Therapy-ongoing, 24-Hour monitoring by "counseling" staff-ongoing) provided to her during her admission; -documentation of a crisis plan with possible use of safety strategies to address her behaviors during crisis situations. Review on 10/16/20 of individual therapy notes for Client #10 revealed: -9/29/20, she was placed on Self-Focused by her therapist for 48 hours to process a pattern of behaviors that were "negatively" impacting her. This intervention included her being given written and reading assignments to help confront her behavior, she was to remain within 10 feet of staff, was to only verbally communicate to staff about her needs (bathroom and food), and was to use her free time to complete her assignments from her therapist; -10/2/20 (3 days later), she was removed from Self-Focused after she met with her Team Manager (unnamed) and her assignments were reviewed and the Team Manager consulted with her therapist. Interview on 11/2/20 with Client #10 revealed:	V 112		

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V 112	Continued From page 33 -she was placed on Self-focus by her therapist during a therapy session for lying behaviors; -Self-focus was a lighter version of Safety and included 6 or 7 assignments from her therapist she had to complete to be taken off the intervention which came with restrictions; -her restrictions included being "tagged" with staff at 10 feet away, sleeping in the common area, only being able to talk with staff about need-based things (use of bathroom),and she lost privileges-no makeup, could not read books of her choice, no media, had "hefty" assignments to complete, and could not talk with her parents on social calls; -she was on Self-Focus about 48 hours. Record review on 9/28/20 for Former Client (FC) #12 revealed: -Admission date -12/20/18 -Discharge date - 3/30/20 -Age-18 years -Diagnoses - Anxiety Disorder, Depressive Disorder, Attention Deficit Hyperactivity Disorder, Cannabis Use Disorder, Oppositional Defiant Disorder, Conduct Disorder; Her current plan dated 3/2/20 goals included: "-will resolve the core conflicts which contribute to emergence of sexualized behaviors; -develop relationship skills to maintain a successful relationship with parents; -Develop trust in parents to be open/honest; -increase ability to communicate in an assertive manner with parents; -terminate addictive behavior and resolve parent-child relationship conflicts; -will report an improved ability to control intense emotions such as anger and anxiety; -replace hostile, defiant behaviors towards adults with respect and cooperation; -understand the relationship between anger	V 112		

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feelings and the feelings of hurt and worthlessness;
-symptoms of depression will be significantly reduced and will no longer interfere with daily functioning;
-resolve the conflict that underlies the anger, hostility and defiance ..."
-there was no identified person responsible for the program services to be provided to the client.
-plan dated 3/2/20 with no guardian signature or documentation that indicated the guardian's participation in or agreement to her treatment plan nor any signature from FC #12.
-there were no strategies/objectives to direct staff or client in learning to progress toward goals.

Attempted interviews on 11/6/20 and 11/9/20 with FC #12 revealed:
-there was no answer when a call was made to the telephone number provided;
-her voicemail was not set up for surveyor to leave a message and request a return call.

Record review on 9/28/20 for FC #13 revealed:
-Admission date - 1/24/19
-Discharge date - 5/12/20
-Age-16 years
-Diagnoses - Adjustment Disorder, Parent Child Relational Problem, Learning Disorder Not Otherwise Specified, Cannabis Use Disorder;
-treatment plan dated 12/23/19 included the following goals:
-will create and implement a reunification plan with caregivers
-will actively participate in taking accountability for her own actions without becoming hostile, ashamed, blaming others, minimizing, avoiding or aggressing
-will demonstrate an improved ability to maintain healthy social/emotional boundaries

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V 112	Continued From page 35 -will improve ability to take accountability for own actions and part in success and difficulties in interpersonal relationships -will demonstrate an improved self-worth -will learn to improve distress tolerance and ability to cope with difficult and overwhelming emotions -will improve ability to access support system -will explore and resolve issues related to past traumas -will learn and implement calming coping strategies in order to manage emotional reactions to trauma -will learn to identify, express and manage emotions in a safe and effective manner -plan had no guardian signature or documentation that indicated the guardian's participation in or agreement to her treatment plan nor any signature from FC #13. -plan also had no therapist signature. -program services in this master treatment plan included "24 hour monitoring by counseling staff, group therapy (x5 weekly), individual therapy (weekly) and family therapy (weekly) would start on 12/23/19 and end on 12/23/2119." -There was no identified person responsible for the program services to be provided to the client . Interview on 11/6/20 with FC #13 revealed she signed a plan when she first arrived but didn't remember a second plan. Record review on 9/28/20 for FC #14 revealed: -Admission date- 10/24/18 -Discharge date - 4/6/20 -Age-17 years -Diagnoses - Major Depressive Disorder, General Anxiety Disorder, Post Traumatic Stress Disorder, Parent Child Relational Problem, Cannabis Use Disorder; -plan dated 3/15/20 included the following goals:	V 112		

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V 112	Continued From page 36 -will report a significant improvement in mood -sense of well being -will achieve a substantial reduction in symptoms of anxiety -will be able to consistently regulate emotional states with appropriate boundaries -build trust with parents -plan had no guardian signature or documentation that indicated the guardian's participation in or agreement to her treatment plan nor any signature from FC #14. -program services in this master treatment plan included "Threshold start on 6/8/20 and end on 6/8/2108." -there were no strategies/objectives to direct staff or client in learning to progress toward goals. -there was no identified person responsible for the program services to be provided to the client. -Interview on 11/6/20 with FC #14 revealed she did not remember participating in creating a treatment plan. Record review on 9/30/20 for FC #15 revealed: -Admission date - 6/8/20 -Discharge date - 8/27/20 -Age-16 years -Diagnoses - Autism Spectrum Disorder, Attachment Disorder, Major Depressive Disorder, Generalized Anxiety Disorder, Attention Deficit Hyperactivity Disorder, Parent Child Relational Problem; -Treatment plan dated 6/8/20 revealed the following goals: -stabilize mood and tolerate changes in routine and environment -engage in reciprocal and cooperative interactions with other on a regular basis. -will improve ability to develop genuine intimacy or closeness with others	V 112		

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V 112	Continued From page 37 -will demonstrate an improved ability to maintain healthy social/emotional boundaries -will improve the ability to take accountability for own actions and part in success/difficulties in relationships -will be able to communicate her needs to others -will improve the ability to manage depression while maintaining safe behaviors -will learn to identify, express and manage emotions in a safe effective manner -will improve ability to access support system -will reduce overall frequency, intensity and duration of anxiety episodes in order to improve daily functioning -will sustain attention and concentration for consistently longer periods of time -will improve self esteem -will demonstrate marked improvement in impulse control -plan dated 6/8/20 had no guardian signature or documentation that indicated the guardian's participation in or agreement to her treatment plan nor any signature from FC #15. -program services in this master treatment plan included "individual therapy (x1 weekly), 24 hour monitoring by counseling staff, group therapy (x3 weekly), and family therapy (x2 weekly) would "start on 3/15/20 and end on 3/15/2120" -there was no identified person responsible for the program services to be provided to the client. Interview on 11/19/20 with guardian via email for FC #15 revealed: "As we understood Solstice East they follow a certain model of relational therapy using a phased program to work the kids through increasing levels of understanding their issues and developing coping skills and competencies to bring them back to home. [FC#15] was at the	V 112		

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very early stages of this program and her own journey where even basic self-care was still challenging and she had not yet moved into feeling safe at Solstice. Therefore therapy and a plan to support it was quite limited. We were in weekly communication with the therapist and with [FC #15] but a formal plan was not developed with our inputs, though we had plenty of air time to provide background on [FC #15] and our views on her situation."

Record review on 9/30/20 for FC #16 revealed:
-Admission date - 10/7/19
-Discharge date - 5/12/20
-Age-17 years
-Diagnoses - Major Depressive Disorder, Attention Deficit Hyperactivity Disorder, Social Anxiety Disorder, Parent Child Relational Problem;
-Treatment Plan dated 11/7/19 goals included:
-will report significant improvement in mood and sense of well being
-will be able to achieve a significant increase in compensatory skills for management of ADHD symptoms
-will achieve a significant reduction in symptoms of anxiety.
-Plan had no guardian signature or documentation that indicated the guardian's participation in or agreement to her treatment plan nor any signature from FC #16 .

Interview with guardian on 11/10/20 revealed:
-FC #16 didn't complete treatment at Solstice East;
-the guardian did not recall specifics about creating a treatment plan;
-FC #16 committed suicide 2 weeks earlier.

Record review on 10/12/20 for FC #18 revealed:

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V 112	Continued From page 39 -Admission date -1/2/20 -Aischarge date -10/3/20 -Age-17 years -Diagnoses - Post Traumatic Stress Disorder, Major Depressive Disorder, Generalized Anxiety Disorder, Attention Deficit Hyperactivity Disorder, Specific Learning Disorder, Cannabis Use Disorder, Mood Dysregulation Disorder; -Treatment Plan dated 2/28/20 included the following goals: -will demonstrate an improved ability to manage mood and return to previous level of effective functioning; -will increase his/her emotional vocabulary to communicate feelings to others; -will demonstrate an improved ability to manage negative thoughts and feelings; -will process past trauma that contributes to mood dysregulation. -plan had no guardian signature or documentation that indicated the guardian's participation in or agreement to her treatment plan nor any signature from FC #18. -Treatment Plan start date 2/28/2020 end date 2/28/2120 and signed on 3/2/20 -no strategies Attempted interview on 11/6/20 and 11/9/20 with FC #18's guardian revealed: -No response from FC #18 during the survey. Interview on 11/23/20 with Clinical Director revealed: -she had only been clinical director for a few months. -"there were documentation gaps in general-notes and treatment plans, discharge reports..." -she indicated there were various types of client notes-treatment team notes, therapist notes, shift notes which the therapists constantly reviewed	V 112		

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with the clients and staff.
-the client notes were in different locations and needed to be found in a centralized location- the electronic client record system-in "Blue Step."
-the therapists needed to document their clinical rational for clients' extensions related to Safety and safety precautions.
-she did not respond to there being no strategies related to the client goals in the treatment plans.
-She would expect to see signatures of all participant's signatures on treatment plans.

Interview on 11/17/20 with Counselor #3 revealed:
-treatment plans were to be completed within the first 30 days of a client's admission;
-the plans were developed from the facility assessment that was completed within the first 24 hours and included prior client evaluations and a first client meeting;
-each client saw their treatment plan and had an opportunity for input into their plan;
-the plans were "generic" with a drop-down menu based on a client diagnosis.

Interview on 11/9/20 with Former Therapist #4 revealed:
-Therapist built the treatment plans from the intake assessments and goals of the students and family. The first family session was developing the goals and objectives with the family- met with the parents first and then had the student brought in and went over the goals and objectives and made sure everyone was in agreement.

Interview on 9/29/20 with the Operations Director revealed:
-the facility was transitioning from one electronic client record system to another and not all of the

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V 112	Continued From page 41 clients' treatment plan information had carried over to the new system; -she indicated she was still in the process of working with the developer to get this problem resolved. This deficiency constitutes a recited deficiency. This deficiency is cross referenced into 10A NCAC 27E .0101 Least Restrictive Alternative (V513) for a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 112		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the	V 118	V118-Medication Requirements: Facility failed to ensure medications were administered only on the written order of a person authorized by law to prescribe drugs and failed to ensure MARs of all drugs administered to clients were kept accurate and current. Solstice East's Governing Body reviewed Tag V118 and gave direction for the following corrections, preventative measures and ongoing monitoring to take place: Correction: A training was provided to med trained staff on 12/3/20, which included: 1. Review of medication error trends. 2. Review of tools in the eMAR to prevent missed medications and check for medication pass completion. 3. Proper incident report completion for medication related events. An incident report checklist was provided to med givers to reference when completing an IR for medication incidents. Checklist includes pertinent information that needs to be included in each incident report and clarifies previous points of confusion. 4. Review of patterns and mistakes identified during incident report audits. 5. When to contact the nurse or nurse on call for medication related questions or events.	

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V 118	Continued From page 42 drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure medications were administered only on the written order of a person authorized by law to prescribe drugs and failed to ensure MARs of all drugs administered to clients were kept accurate and current affecting 11 of 11 current clients audited (Clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10 and #11) and 1 of 7 Former Clients (FC #16). The findings are: Cross Reference: 10A NCAC 27G.0209(h) - Medication Requirements (V123). Based on record reviews and interviews the facility failed to immediately notify the physician or pharmacist for drug administration errors and failed to properly record the errors in the clients' drug record affecting 6 of 11 current clients audited (Clients #4, #5, #6, #7, #8, and #9) and 1 of 7 Former Clients (FC #16) audited. Finding #1: Excel summary of incident reports provided by facility indicating medication errors not reflected on MARs (Clients #4, #7, #8, #9 and #11). Record review on 9/30/20 for Client #4 revealed:	V 118	Continued From page 42 A quiz was given to demonstrate comprehension of topics in the above training. A follow up training occurred on 12.22.20 to review the quiz from 12.3.20 and discuss continued patterns or questions related to medication administration. Medical coordinator and registered nurse developed a system for keeping all physicians orders organized in one central location. Medication Order Policies were changed to clarify order implementation process. New orders are reviewed and processed by a Registered Nurse. Contracted physicians will notify the Registered Nurse on call for any orders that need urgent implementation. A medication recap was performed in December 2020 to review each client's current MAR in comparison to medications in the client's bin and physician's orders. Any discrepancies found were followed up with by organizing orders in a central location and seeking discontinuation orders for PRN medications no longer needed. Prevention and Monitoring: Registered Nurse or qualified designee completes MAR and Physicians Orders audit weekly. MAR audit is performed to identify medication errors not previously reported to the nurse/nurse on call, and to confirm that new orders have been implemented and signed by the prescriber. Physicians are notified of orders pending signature weekly. Providers are required to sign verbal orders within 14 days. Registered nurse or qualified designee performs weekly cross referencing of the eMAR to Incident Reports, including: 1. Review of incident reports for medication related events (medication error, refusal, etc). 2. Review of eMAR documentation for accuracy and currency. 3. Comparison of eMAR documentation to incident report.	

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V 118	Continued From page 43 -Admission date- 8/29/19 -Age- 16 years -Discharge date-10/8/20 -Diagnoses- Other Specified Trauma-and Stressor-Related Disorder With Attachment Problems, Other Specified Bipolar and Related Disorder: Short Duration Hypomanic Episodes And Major Depressive Episodes; Other Specified Anxiety Disorder; Other Specified Neurodevelopmental Disorder With Deficits In Visual Spatial Abilities, Attention-Deficit/Hyperactivity Disorder, Combined Type. Record review on 11/4/20 of Client #4's physician's orders from 3/5/20 through 9/24/20 included: -there were no standing orders signed to include Diphenhydramine (Benadryl) - 25 mg (milligrams)- 1 to 2 every 6 hours PRN (as needed). -3/31/20- Melatonin 1 mg every HS (bedtime). -3/31/20- Nordic Naturals Ultimate Omega Jr- 1 capsule twice a day. -7/5/20 - Lamictal 100 mg - 1.5 tablets every a.m. -7/5/20- Clonidine ER 0.1 mg - take 2 tablets every 7:30 p.m. (after dinner). Record review on 11/16/20 of the Excel summary of incident reports provided by facility from May 2020 through October 2020 for Client #4 revealed: -6/27/20 - wrong dose - Diphenhydramine HCL (Benadryl) - 2 caps of 50 mg given - they were thought to be 25 mg tablets. -7/28/20 - late medication - Clonidine HCL ER 0.1 mg tablet - client initially refused but few minutes later agreed to take. -7/29/20 - medication refused - pattern of refusal started 7/29/20 where she refused all p.m.	V 118	Continued From page 43 Registered Nurse or qualified designee performs a medication recap monthly, reviewing each client's current MAR in comparison to medications in the client's bin. Discrepancies found will be corrected by obtaining a new order, discontinuation order, or medication refill. Contracted medical provider performs monthly PRN medication clean-up to review ongoing necessity of medication regimen and provide discontinuation orders as necessary. Registered Nurses will provide monthly in-services covering the following topics: 1. New patterns identified in audits 2. Updates to policies and procedures 3. Other relevant information as needed Medical coordinator, second nurse, or other qualified designee will complete a second review of the following audits: 1. Monthly Medication Recap audit 2. Weekly Mar/ Physicians Orders audit 3. Weekly Cross Referencing of eMAR to incident reports audit Auditing will continue per above plans until substantial compliance is met and maintained as directed by the Governing Body.	

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V 118	Continued From page 44 medications. On 7/30/20 and 7/31/20 - a.m. medications all late due to client initially refusing and later agreeing to take them. Starting on 7/31/20 p.m. through 8/2/20 - all medications had been refused up until the time of hospitalization on 8/2/20. (See tag V112 for additional information.) -8/13/20 - late medication - Clonidine HCL ER 0.1 mg tablet - staff unaware of medication to be given. Record review on 11/16/20 of Client #4's MARs from May 2020 through October 2020 revealed: -6/27/20 - Diphenhydramine HCL 25 mg cap - one to two capsules every 4-6 hours PRN - initialed as given PRN - there were no exception notes of being given wrong dose. -7/28/20 - Clonidine HCL ER 0.1 mg tablet - initialed as given - there were no exception notes to indicate the medication was given late. -7/29/20 and 7/31/20 - Clonidine HCL ER 0.1 mg tablet - 2 tablets after dinner; Nordic Natural Ultimate Omega Jr. - 1 capsule 2 times a day-9:00 p.m.; Pure Lithium Orotate 5 mg - 2 capsules at bedtime - were all blank - there were no exception notes indicating the medication was initially refused and given late. -8/1/20 - B-Complex with B12 tablet - 1 tablet every a.m.; Clonidine HCL ER 0.1 mg - 2 tablets after dinner; Lamotrigine 150 mg - 1 tablet every a.m.; Nordic Natural Ultimate Omega Jr. - 1 capsule 2 times a day; Pure Lithium Orotate 5 mg - 2 capsules at bedtime - were all blank - there were no exception notes indicating the medications were refused. -8/13/20 - Clonidine HCL ER 0.1 mg - 2 tablets after dinner - initialed as given - there were no exception notes indicating the medication was late.	V 118		

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Record review on 9/28/20 for Client #7 revealed:
-Admission date-6/28/19
-Age- 18 years
-Diagnoses- Persistent Depressive Disorder (Dysthymia), Attention-Deficit Hyperactivity Disorder, Gender Dysphoria in Children, Parent-Child Relational problem Generalized Anxiety Disorder, Child Sexual Abuse (History).

Record review on 11/16/20 of Client #7's physician orders dated 2/20/20 through 10/20/20 revealed:
-2/20/20- Lo Estrin Fe- 1 mg/20 mcg- 1 tablet every a.m. - first Sunday after start of menses.
-3/5/20- Cymbalta - 50 mg - every a.m.
-5/4/20- Citracal +D - 1 capsule twice a day.
-5/4/20- N-acetylcysteine 1200 mg - twice a day.
-5/4/20- Natural Whole Food Multivitamin for Women- 2 capsules twice a day - discontinued 6/19/20.
-6/10/20- Vitamin D3 2000 units - 1 daily.
-7/16/20- Concerta 18 mg - 1 tablet every a.m.

Record review on 11/16/20 of the Excel summary of incident reports provided by facility from May 2020 through October 2020 for Client #7 revealed:
-6/10/20 - late medication - "6pm meds. student and staff forgot medication within window. Medications were given shortly after medication window closed."
-6/19/20 - late medication - all a.m. medications
-6/23/20 - late medication - all a.m. medications
-7/20/20 - late medication - all a.m. medications

Record review on 11/16/20 of Client #7's MARs from May 2020 through October 2020 revealed:
-6/9/20, 6/19/20, 6/23/20 and 7/20/20- all medications were initialed as given - there were

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V 118	Continued From page 46 no exceptions noted to indicate any medication was given late. Record review on 10/12/20 for Client #8 revealed: -Admission date- 10/31/19 -Age- 16 years -Diagnoses- Adjustment Disorder, Unspecified, Oppositional Defiant Disorder, Major Depressive Disorder, Cannabis Use Disorder, Moderate, In A Controlled Environment. Record review on 11/16/20 of Client #8's physician orders dated 10/31/19 through 10/30/20 revealed: -6/10/20- Bayer Womens One-a-Day Multivitamin - 1 tablet every a.m. -7/13/20- Duloxetine DR 20 mg - 1 capsule every p.m. (dinner). -8/7/20 - Change Duloxetine DR 20 mg to 40 mg - 1 capsule every p.m. (dinner). -One a Day Teen Vitacrave - no orders Record review on 11/16/20 of the Excel summary of incident reports provided by facility from May 2020 through October 2020 for Client #8 revealed: -7/16/20 - late medication - Duloxetine HCL DR 20 mg - the client thought the medication was to be taken at bedtime. -9/21/20 - wrong time - no medication listed. -9/24/20 at 10:48 a.m. and 1:55 p.m. missed medication - One a Day Teen Vitacrave - staff accidentally sent it back to pharmacy. Second missed medication at 1:55 p.m. was not listed. No other notes regarding what other medication was missed. Record review on 11/16/20 of Client #8's MARs from May 2020 through October 2020 revealed: -7/16/20 - Duloxetine HCL Dr 20 mg - 1 capsule	V 118		

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every evening at dinner - initialed as given - no exceptions noted to indicate medication was given late.
-9/21/20 - all medications initialed as given - no exceptions noted - cannot determine which medication was given at the wrong time.
-9/24/20 - One A Day Teen Vitacrave - 1 gummy once a day - only exception noted- all other medications were initialed as given.

Record review on 10/12/20 for Client #9 revealed:
-Admission date- 3/16/20
-Age- 16 years
-Diagnoses- Major Depressive Disorder, Recurrent Severe, Personal History Of Self-harm, Anxiety Disorder, Unspecified, Attention-Deficit Hyperactivity Disorder, Unspecified Trauma-And Stressor-Related Disorder.

Record review on 11/16/20 of Client #9's physician orders dated 4/23/20 through October 2020 revealed:
-4/23/20-Prazosin - increase to 4 mg every HS on 4/27/20.
-4/23/20- Lithium Orotate 5 mg - 2 times a day.
-5/12/20- Theanine - increase serene - 2 capsules twice a day.
-5/26/20- Lamictal 100 mg - 2 times a day.
-5/26/20- Prazosin - increase to 6 mg every HS.
-5/27/20- Lithium Orotate - increase to 10 mg - 2 times a day.
-6/15/20- Melatonin 3 mg - 1 tablet every HS.
-6/19/20- Change Lithium Orotate to 10 mg - 1 tablet after breakfast and 1 after dinner.
-7/14/20- Chaste Tree (225 mg) pure encapsulations - 1 capsule every HS.
-8/24/20-Discontinue Nystatin 250,000 units twice a day for 2 weeks, then increase to 500,000 unit twice a day.
-8/24/20 - Klaire labs candida complex - 1

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V 118	Continued From page 48 capsule every a.m. Record review on 11/16/20 of the Excel summary of incident reports provided by facility from May 2020 through October 2020 for Client #9 revealed: -5/3/20 and 5/6/20 - wrong dose was documented both days with the same information - Prazosin 2 mg - 6 mg given instead of 4 mg - red alarm went off when staff scanned the medication cassette, however staff continued to give the wrong dose. -6/24/20 - late medication - Lithium Orotate 5 mg - client and staff forgot about the medication change. -7/2/20- missed medication - the medication was not listed. -9/22/20 - late med - the medication was not listed. -10/11/20 - late medication - supplement was late due to staff error. Record review on 11/16/20 of Client #9's MARs from May 2020 through October 2020 revealed: -5/3/20 and 5/6/20 - Prazosin 2 mg - 2 capsules (4 mg) once daily - initialed as given - no exception noted to indicate the wrong dose was given. -6/24/20 - Lithium Orotate 5 mg capsules - 1 capsule twice a day - initialed as given - no exception noted to indicate medication was late. -7/2/20- Pure Lithium Orotate blank for 7 p.m. - no exception noted - cannot determine if this was the missed medication. -9/22/20 - all medications initialed as given - no exceptions noted - cannot determine what medication was late. -10/11/20 - all medications were initialed as given - no exception was noted to indicate what supplement was late.	V 118		

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V 118	Continued From page 49 Interview on 11/3/20 with Nurse #1 and Nurse #2 revealed: -too much Prazosin would cause sleepiness or dizziness - it was used to treat nightmares. -when asked about the discrepancies between incident reports and MARs - they indicated they were unaware of the discrepancies. Record review on 10/12/20 for Client #11 revealed: -Admission date-7/7/20 -Age-17 years -Diagnoses- Post-Traumatic Stress Disorder, Persistent Depressive Disorder (Dysthymia), Attention-Deficit Hyperactivity Disorder -Combined Presentation, Generalized Anxiety Disorder, Parent-Child Relational Problem. Record review on 11/16/20 of Client #11's physician orders dated July 2020 through October 2020 revealed: -9/2/20-Adderall XR 10 mg - 1 tablet every a.m. school days only - Monday through Thursday. -8/26/20- Lexapro - decrease to 5 mg - every HS. -8/26/20- Start Cymbalta- 20 mg every a.m. for 15 days, then increase to 30 mg every a.m. "...#15 of the 20 mg, #30 of the 30 mg, plus 1 refill. -8/13/20- Adderall 5 mg - 1 tablet every lunchtime - Monday through Thursday. Record review on 11/16/20 of the Excel summary of incident reports provided by facility from July 2020 through October 2020 for Client #11 revealed: -9/24/20 - missed medication - medication not listed. Record review on 11/16/20 of Client #11's MARs from July 2020 through October 2020 revealed: -9/24/20 - all medications were initialed as given -	V 118		

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no exceptions were noted to indicate what medication was missed.

Finding #2: Observed medications with no orders (Clients #2, #5, #7 and #8)

Record review on 9/28/20 for Client #2 revealed:
-Admission date- 5/13/19
-Age-16 years
-Diagnoses- Unspecified Anxiety Disorder, Major Depressive Disorder-Recurrent w/ Psychotic Features, Disruption of Family By Separation Or Divorce, Parent-Child Relational Problem.

Observation on 11/2/20 at approximately 12:50 p.m. of Client #2's medications included:
-Hydroxyzine HCL 25 mg - 1 tab at bedtime (HS)
-Gaia Herbs Thyroid Support - 2 caps in am; 1 cap at HS
-Ture Aloe w/ Organic Aloe - 1 cap 2 times day
-Pro Omega 1000 plus D - 1 at HS
-Prevident 5000 ppm Sensitive - brush for 2 min before HS - do not rinse
-Hydroxzine (Visteral) PAM 25 mg - 1-2 cap PRN before lab draw
-LO Loestrin FE 1-10 - 1 tab daily
-Vitamin D3, 5,000 unit - ½ tab Q am
-Veeva -Theanine & Magnesium - Avec w/ Vitamins B - 1 cap 2 times a day
-Albuterol Sul HFA 90 mcg - Inhale 2-4 puffs every 4 hours PRN
-Acetaminophen 325 mg - 1 tab 2 times a day for 2-3 weeks
-Hydrocortisone 1% cream - apply to affected area 3-4 times a day PRN.

Record review on 11/16/20 of Client #2's physician orders dated 3/5/20 through 10/13/20 revealed:
-there were no orders for Hydroxyzine HCL 25

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mg; Gaia Herbs Thyroid Support; Ture Aloe w/ Organic Aloe; Pro Omega 1000 plus D; Prevident 5000 parts per million (ppm) Sensitive; Hydroxzine (Visteral) PAM 25 mg; LO Loestrin FE 1-10; Vitamin D3, 5,000 unit; Veeva -Theanine & Magnesium - Avec w/ Vitamins B; and Albuterol Sul HFA 90 mcg.
-there were no Over-The-Counter (OTC) standing orders for Acetaminophen 325 mg and Hydrocortisone 1% cream.

Record review on 11/16/20 of Client #2's MARs from May 2020 through October 2020 revealed:
-Hydroxyzine HCL 25 mg - 1 tab at bedtime - given daily - another entry listed as PRN had not been given.
-Gaia Herbs Thyroid Support - 2 caps in am; 1 cap at HS - given daily.
-Ture Aloe w/ Organic Aloe - 1 cap 2 times per day - given daily.
-Pro Omega 1000 plus D - 1 at bedtime (HS) - given daily.
-Prevident 5000 ppm Sensitive - brush for 2 min before HS - do not rinse - given daily.
-Hydroxzine (Visteral) PAM 25 mg - 1-2 cap PRN before lab draw - not given.
-LO Loestrin FE 1-10 - 1 tab daily - given daily.
-Vitamin D3, 5,000 unit - ½ tab Q am - given daily.
-Veeva -Theanine & Magnesium - Avec w/ Vitamins B - 1 cap 2 times a day - given daily.
-Albuterol Sul HFA 90 mcg - Inhale 2-4 puffs every 4 hours PRN - given 5/31/20, 9/29/20, and 10/19/20.
-Acetaminophen 325 mg - 1 tab 2 times a day for 2-3 weeks - given 6/5/20, 6/8/20; 7/2/20, 7/4/20 x 2, 9/7/20, 9/11/20, 10/1/20-10/9/20 - 2 times a day - then "DC'd [discontinue]" indicated.
-Hydrocortisone 1% cream - apply to affected area 3-4 times a day PRN - given 8/29/20.

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V 118	Continued From page 52 Record review on 9/28/20 for Client #5 revealed: -Admission date-4/9/20 -Age- 17 years -Diagnoses- Post-traumatic Stress Disorder, Major Depressive Disorder, Substance Abuse Disorder-Severe, Parent-child Relational Problem, Personal History of Childhood Physical Abuse, Chronic Headaches And Back Pain (motor vehicle accident) 2/2018; Gastro-esophageal Disorder/Gastritis; Left Knee meniscus repair (x2) (Summer 2019); Concussion (x 7); History of broken arm in 5th grade from roller skating. Observation on 11/2/20 at approximately 10:54 a.m. of Client #5's medications included: - Sodium Fluoride 5000 Plus CRM 1.1% - brush teeth for 2 minutes before bedtime. Record review on 11/16/20 of Client #5's physician orders dated 4/9/20 through 10/7/20 revealed: -no order for Sodium Fluoride 5000 Plus 1.1% Record review on 11/16/20 of Client #5's MARs from May 2020 through October 2020 revealed: -Sodium Fluoride 5000 Plus CRM started on 9/3/20 and then daily thereafter. Interview on 11/2/20 with Nurse #2 revealed: -the client started the tooth paste on 9/3/20 and self-administered. Record review on 9/28/20 for Client #7 revealed: -Admission date-6/28/19 -Age- 18 years -Diagnoses- Persistent Depressive Disorder (dysthymia), Attention-Deficit Hyperactivity Disorder, Gender Dysphoria in Children,	V 118		

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V 118	Continued From page 53 Parent-Child Relational problem Generalized Anxiety Disorder, Child Sexual Abuse (history). Observation on 11/2/20 at approximately 11:20 a.m. of Client #7's medications included: -Lamotrigine (Lamictal) 100 mg - 1 tablet - 2 times a day. -Triamcinolone Acetonide Ointment USP 0.1% - apply to affected areas 2 times a day. -Equate Nasal Spray - OTC Saline. - Levothyroxine (Synthroid) 100 micrograms (mcg) - 1 tab daily. Record review on 11/16/20 of Client #7's physician orders dated 2/20/20 through 10/20/20 revealed: -no orders for Lamotrigine, Triamcinolone Acetonide Ointment USP 0.1% and Levothyroxine. -there were no OTC standing orders for Equate Nasal Spray. Record review on 11/16/20 of Client #7's MARs from May 2020 through October 2020 revealed: - Lamotrigine (Lamictal) 100 mg - 1 tablet - 2 times a day - given daily. -Triamcinolone Acetonide Ointment USP 0.1% - apply to affected areas 2 times a day - given 10/20/20. -Equate Nasal Spray - OTC Saline - not listed. - Levothyroxine (Synthroid) 100 mcg - 1 tab daily - given daily. Interview on 11/2/20 with Nurse #2 revealed: - the client used Triamcinolone Acetonide Ointment USP 0.1% once in the last 30 days. Record review on 10/12/20 for Client #8 revealed: -Admission date- 10/31/19	V 118		

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V 118	Continued From page 54 -Age- 16 years -Diagnoses- Adjustment Disorder, Unspecified, Oppositional Defiant Disorder, Major Depressive Disorder, Cannabis Use Disorder, Moderate, in a controlled environment. Observation on 11/2/20 at approximately 11:47 a.m. of Client #8's medications included: -Sucralfate 1 gram (gm) (Carafate) - 1 tab up to 4 times day - PRN. -One a Day Teen Vitacrave - 1 gummie a day. -Melatonin 2.0 mg - OTC. Record review on 11/16/20 of Client #8's physician orders dated 10/31/19 through 10/30/20 revealed: -there were no orders for Sucralfate, One a Day Teen Vitacrave, and Melatonin. Record review on 11/16/20 of Client #8's MARs from May 2020 through October 2020 revealed: -Sucralfate 1 gm (Carafate) - 1 tab up to 4 times day - PRN - given 8/28/20, 9/20/20, 10/27/20 and 10/28/20. -One a Day Teen Vitacrave - 1 gummie a day. - started 6/21/20 and given daily thereafter. -Melatonin 2.0 mg - OTC - not listed. Finding #3: Medications not observed that have current orders (Clients #1, #2, #5, #6, #7, #9 and #11) Record review on 9/28/20 for Client #1 revealed: -Admission date- 8/19/20 -Age-14 years -Diagnoses- Major Depressive Disorder -Recurrent, Generalized Anxiety Disorder, Parent-Child Relational Problem, Attention-Deficit Hyperactivity Disorder -Predominantly inattentive presentation.	V 118		

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V 118	Continued From page 55 Record review on 11/16/20 of Client #1's physician orders dated 8/19/20 through 10/30/20 revealed: -10/30/20 - "Start Methylphenidate ER [extended release] 18 mg - Take 1 po [by mouth] Q [every] AM for 7 days ..." Observation on 11/2/20 at approximately 10:45 a.m. of Client #1's medications revealed: - Methylphenidate ER 18 mg - was not included with her medications. Record review on 11/16/20 of Client #1's MAR for October 2020 revealed: - Methylphenidate ER 18 mg - was not listed for 10/30/20 or 10/31/20. Record review on 11/16/20 of Client #2's physician orders dated 3/5/20 through 10/13/20 revealed: -4/20/20 - "Ice Hot Patches - Apply as directed, as needed." Observation on 11/2/20 at approximately 12:50 p.m. of Client #2's medications revealed: -Ice Hot Patches were not included with her medications. Record review on 11/16/20 of Client #2's MARs for May 2020 through October 2020 revealed: -Icy Hot Medicated Patch 5% - was administered 10/27/20. Record review on 11/16/20 of Client #5's physician orders dated 4/9/20 through 10/7/20 revealed: -4/9/20 - "Hydroxyzine HCL 25 mg - One to two tabs PO [by mouth] Q [every] 6H [hours] PRN for anxiety/insomnia."	V 118		

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V 118	Continued From page 56 -6/10/20 - "Debrox 6.5% Ear Drops insert into affected ear as directed PRN ear wax build up." Observation on 11/2/20 at approximately 10:54 a.m. of Client #5's medications revealed: -Hydroxyzine 25 mg and Debrox 6.5% Ear Drops were not included with her medications. Record review on 11/16/20 of Client #5's MARs for May 2020 through October 2020 revealed: -Hydroxyzine HCL 25 mg - One to two tabs every 6 hours PRN - was given 5/30/20, 5/31/20, 6/9/20, 7/30/20, 8/20/20, and 10/25/20. -Debrox 6.5% Ear Drops - was administered twice a day 5/15/20 through 5/18/20 - highlighted at the top was "DC'd." Record review on 9/28/20 for Client #6 revealed: -Admission date-3/25/20 -Age- 15 years -Diagnoses- Parent Child Relational Problem, Other specified Trauma-and stressor-related Disorder. Record review on 11/16/20 of Client #6's physician orders dated 10/30/20 revealed: -"Colace 50 mg po BID [2 times a day] PRN constipation." Observation on 11/2/20 at approximately 11:08 a.m. of Client #6's medications revealed: -Colace 50 mg was not included with her medications. Record review on 11/16/20 of Client #6's MARs for October 2020 revealed: -Colace 50 mg - was not listed. Record review on 11/16/20 of Client #7's physician orders dated May 2020 through	V 118		

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V 118	Continued From page 57 October 2020 revealed: -4/6/20 - "Albuterol MDI (Proair HFA) 90 mcg/actuation - 1-2 puffs Q4-6 hours PRN dyspnea or wheezing." -6/10/20 - Vitamin D3 2,000 units - one daily. -Lactase 3,000 unit - 1 tab before eating lactose PRN - not ordered. Observation on 11/2/20 at approximately 11:20 a.m. of Client #7's medications revealed: -Albuterol MDI (Proair HFA) 90 mcg/actuation, Vitamin D3 2,000 and Lactase 3,000 was not included with her medications. Record review on 11/16/20 of Client #7's MARs for May 2020 through October 2020 revealed: -Albuterol MDI (Proair HFA) 90 mcg/actuation - administered x 9. -Vitamin D3 2,000 units - 1 tablet daily - was started 5/23/20 and given daily thereafter. -Lactase 3,000 unit - given 10 x May, 15 x June, 16 x July, 16 x August,14 x September, and 11 x October. Record review on 11/16/20 of Client #9's physician orders dated 4/23/20 through October 2020 revealed: -4/13/20 - Magnesium Buffered Chelate - 2 capsules daily. -4/23/20 - "increase to Nystatin to 500,000 units PO BID." -6/10/20 - Debrox 6.5% ear drops - place in each ear PRN. -6/22/20 - Propranolol 10 mg - 1 tablet daily PRN. Observation on 11/2/20 at approximately 11:59 a.m. of Client #9's medications revealed: -Magnesium Buffered Chelate, Nystatin 500,000 units, Debrox 6.5 ear drops, and Propranolol were not included with her medications.	V 118		

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V 118	Continued From page 58 Record review on 11/16/20 of Client #9's MARs for May 2020 through October 2020 revealed: -Magnesium Buffered Chelate - 2 capsules daily - given 5/1/20 through 5/12/20 then "DC'd." -Nystatin to 500,000 units - 1 tablet twice a day - started 5/8/20 given daily until 8/25/20 then "DC'd." -Debrox 6.5% ear drops - place in each ear PRN -given 5/15/20 through 5/19/20 then "DC'd" -Propranolol 10 mg - 1 tablet daily PRN - given 2 x June, 9 x July, 2 x August, 3 x September, and 1 x October. Record review on 11/16/20 of Client #11's physician orders dated July 2020 through October 2020 revealed: 7/13/20 - Adderall 5 mg - take 1 PRN once a day between 8 am and 5 pm on Friday, Saturday, and Sunday. -7/13/20 - Tramadol HCl 50 mg - 1 tablet every 6 hours PRN cramps/pain. -7/13/20 - Vienva 0.1 mg/0.02 - 1 tablet every a.m. Observation on 11/2/20 at approximately 12:40 p.m. of Client #11's medications revealed: -Adderall 5 mg - PRN was not included with her medications. -Tramadol HCl 50 mg - PRN - was not included with her medications. -Vienva 0.1 mg/0.02 - was not included with her medications. Record review on 11/16/20 of Client #11's MARs for July 2020 through October 2020 revealed: -Adderall 5 mg - PRN - listed starting in August - not given through October. -Tramadol HCl 50 mg - given 2 x July, 2 x August, 2 x September.	V 118		

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V 118	Continued From page 59 -Vienva 0.1 mg/0.02 - started 7/8/20 and given until 9/29/20 then "DC'd" Finding #4 - MARs inconsistent with observations and/or orders (Clients #4, #7, #8, and #11). Record review on 11/4/20 of Client #4's physician's orders from 3/5/20 through 9/24/20 included: -no orders for B-Complex with Vitamin B12, 1 tablet daily and Pure Lithium Orotate 5 mg - 2 capsules (10 mg) at bedtime. -Vitamin D3 5,000 Unit Tablet - ½ tablet (2500IU) every a.m. was discontinued 5/5/20. -Melatonin 1 mg - 1 tablet at bedtime was discontinued 5/5/20. -5/6/20 "Please monitor BP [Blood Pressure] in AM after 1st dose [Clonidine ER 0.1 mg PO QHS] and if client reports dizziness or feeling lightheaded." -9/21/20 - Trazodone 25-50 mg at bedtime PRN. -9/24/20 - Aripiprazole (Abilify) - increase to 3 mg - 1 tablet at bedtime. Record review on 11/4/20 of Client #4's MARs from May 2020 through October 2020 revealed: -B-Complex with Vitamin B12 - 1 tablet daily - was given daily (except 6/8/20 client refused and 8/1/20 blank). -Pure Lithium Orotate 5 mg - 2 capsules (10 mg) at bedtime - was given daily (except 6/8/20 client refused, and blanks as noted above.) -under instructions to administer B-Complex with Vitamin B12, Clonidine HCL ER 0.1 mg, Green Teas- Decaffeinated in the a.m. on school days, Lamotrigine 100 mg, Nordic Natural Ultimate Omega Jr., and Pure Lithium Orotate 5 mg was "SUSPENDED 10 Jun 2020 to 10 Jun 2020 QEEG**(Brain Scan)." -on 6/10/20 all the above medications to be	V 118		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 60	V 118		

suspended were initialed as given.
-Vitamin D3 5,000 Unit Tablet - ½ tablet (2500IU) every a.m. - last dose given was 5/7/20 (2 days after discontinued).
-Melatonin 1 mg - 1 tablet at bedtime - last dose 5/6/20 (1 day after discontinued.)
-Nordic Natural Ultimate Omega Jr - 1 capsule 2 times daily - 7/13/20 initialed and circled - medication not given due to bottle being empty.
-Blood Pressure- monitor after 1st dose of Clonidine ER 0.1 mg and if client reports feeling dizzy or lightheaded - initialed 5/7/20 then "DC'd."
-Blood Pressure was not listed for June through 9/24/20 when Clonidine was discontinued.
-Aripiprazole (Abilify) - 3 mg - 1 tablet at bedtime - started 10/1/20 (7 days after ordered).

Record review on 11/16/20 of Client #7's physician orders dated May 2020 through October 2020 revealed:
-no order and no discontinue order for Pro Omega 2000 Plus D - 1 capsule day.
-no order for GS Clearlax Powder - mix 1 capful with 4- 8 oz liquid - daily PRN.
-no order for Mupirocin 2% ointment - apply topically to affected picked areas - daily PRN.
-no order for Retin-A 0.025% cream - apply topically to affected area - 1x a day PRN.

Observation on 11/2/20 at approximately 11:20 a.m. of Client #7's medications revealed:
-Pro Omega 2000 Plus D, GS Clearlax Powder, Mupirocin 2% ointment, and Retin were not included with her medications.

Record review on 11/16/20 of Client #7's MARs for May 2020 through October 2020 revealed:
-Pro Omega 2000 Plus D - 1 capsule day - given daily through 6/21/20 then "DC'd."
-GS Clearlax Powder - mix 1 capful with 4- 8 oz

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liquid - daily PRN - given 5 x May, and 7/16/20
- Mupirocin 2% ointment - apply topically to affected picked areas - daily PRN - not given.
- Retin-A 0.025% cream - apply topically to affected area - 1x a day PRN - not given.

Record review on 11/16/20 of Client #8's physician orders dated 10/31/19 through 10/30/20 revealed:
-no orders and no discontinue orders for Methyl B-12 1000 mcg (1mg) and Vital Nutrients Triple Mag 250.

Observation on 11/2/20 at approximately 11:47 a.m. of Client #8's medications revealed:
-Methyl B-12 1000 mcg and Vital Nutrients Triple Mag 250 were not included with her medications.

Record review on 11/16/20 of Client #8's MARs from May 2020 through October 2020 revealed:
-Methyl B-12 1000 mcg (1mg) - 1 tablet daily - given 5/1/20 through 5/18/20 then "DC'd."
-Vital Nutrients Triple Mag 250 - 1 capsule 2 x day - given 5/1/20 through 5/18/20 then "DC'd."
-Vital Nutrients Triple Mag 250 - 1 capsule at bedtime - started 5/18/20 through 6/10/20 then "DC'd."

Record review on 11/16/20 of Client #11's physician orders dated July 2020 through October 2020 revealed:
-no orders for Calcium Carb 500 mg - 2-3 tablets - PRN and Sodium Fluoride 5000 ppm paste.

Observation on 11/2/20 at approximately 12:40 p.m. of Client #11's medications revealed:
-Calcium Carb 500 mg, and Sodium Fluoride 5000 ppm were not included with her medications.

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V 118	Continued From page 62 Record review on 11/16/20 of Client #11's MARs for July 2020 through October 2020 revealed: -Calcium Carb 500 mg - 2-3 tablets - PRN - given 3 x July. -Sodium Fluoride 5000 ppm paste - apply a small amount to tooth brush and brush for 2 minutes a day before bedtime - started 10/19/20 and daily thereafter. Finding #5: Physician orders signed after administration began- affected 2 of 11 current clients (Clients #5 and #10) Record review on 11/16/20 of Client #5's physician orders dated 4/9/20 through 10/7/20 revealed: -5/14/20 - start date - Debrox 6.5% Ear Drops - insert PRN - order signed 6/10/20. -6/18/20 - start date - "Increase prazosin to 6mg PO QHS. Hold Clonidine ER 0.1mg 9pm dose on 6/18/20." - signed 8/26/20. -6/19/20 - start date - "Hold Clonidine ER 9pm dosing through 6/22/20" - signed 8/26/20. Record review on 11/16/20 of Client #5's MARs for May 2020 through October 2020 revealed: -Debrox 6.5% Ear Drops - was administered twice a day 5/15/20 through 5/18/20 - highlighted at the top was "DC'd." -Prazosin 6mg at bedtime was given 6/1/20 through 6/21/20, starting 6/22/20 was given 5 mg. -Hold Clonidine ER 0.1 mg at 9:00 p.m. dose on 6/18/20 - was given 6/18/20 through 6/21/20. -Hold Clonidine ER 9:00 p.m. dosing through 6/22/20 - was not given on 6/22/20 or thereafter. Record review on 10/12/20 for Client #10 revealed: -Admission date-6/8/20 -Age-17 years	V 118		

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V 118	Continued From page 63 -Diagnoses- Other Specified Trauma-And Stressor-Related Disorder, Parent-Child Relational Problem, Attention-Deficit Hyperactivity Disorder, Predominantly Inattentive. Record review on 11/16/20 of Client #10's physician orders dated June 2020 through October 2020 revealed: -10/7/20- start date - Debrox 6.5% ear drops - place into each ear - PRN - signed 10/23/20. Record review on 11/16/20 of Client #10's MARs for June 2020 through October 2020 revealed: -Debrox 6.5% ear drops - place into each ear - PRN - was given 10/8/20, 10/9/20, 10/10/20, and 10/11/20 x2. Finding #6: Medication changes/new orders not implemented timely (Clients #1, #2, #3, #5, #6, #7, #8, #9, #10, and #11) Record review on 11/16/20 of Client #1's physician orders dated 8/19/20 through 10/30/20 revealed: -10/30/20 - start date - Decrease Abilify to 5 mg every HS - signed 10/30/20. -10/30/20 - start date - "Start Methylphenidate ER 18 mg - Take 1 po QAM for 7 days, then increase to 27 mg ..." - signed 10/30/20. Observation on 11/2/20 at approximately 10:45 a.m. of Client #1's medications revealed: -Aripiprazole (Abilify) 10 mg (instead of 5 mg) - 1 tablet at HS. -Methylphenidate ER 18 mg was not included with her medications. Record review on 11/16/20 of Client #1's MARs for October 2020 revealed: -Abilify 10 mg - 1 at HS - was given 10/30/20 and	V 118		

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V 118	Continued From page 64 10/31/20 instead of 5 mg. -Methylphenidate ER 18 mg - was not listed for 10/30/20 or 10/31/20. Record review on 11/16/20 of Client #2's physician orders dated 3/5/20 through 10/13/20 revealed: -10/13/20 - start date -Famotidine (Pepcid) change 20 mg to 1 at bedtime - signed 10/13/20 Record review on 11/16/20 of Client #2's MARs for May 2020 through October 2020 revealed: -Famotidine (Pepcid) was not changed to 1 at bedtime until 10/15/20. Record review on 9/30/20 for Client #3 revealed: -Admission date- 5/11/20 -Age- 15 years -Diagnoses- Major Depressive Disorder -Recurrent, Attention-Deficit Hyperactivity Disorder -Predominantly Hyperactive/Impulsive, Generalized Anxiety Disorder. Record review on 11/16/20 of Client #3's physician orders dated May 2020 through October 2020 revealed: -5/22/20 - start date - "NAC (N-acetylcysteine) 600 mg every a.m. for 7 ..." signed 5/22/20 -10/2/20 - start date - Decrease Abilify to 8 mg every HS - signed 10/2/20. -10/2/20 - start date - Fluoxetine (Prozac) increase from 30 mg to 40 mg daily - signed 10/2/20. Record review on 11/16/20 of Client #3's MARs for May through October 2020 revealed: --NAC (N-acetylcysteine) 600 mg every a.m. did not start until 6/17/20. -Aripiprazole (Abilify) 2 mg - 4 tablets (8 mg) at HS - did not start until 10/5/20.	V 118		

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V 118	Continued From page 65 -Fluoxetine (Prozac) 40 mg daily did not start until 10/6/20. Record review on 11/16/20 of Client #5's physician orders dated 4/9/20 through 10/7/20 revealed: -6/16/20 - start date - Fluoxetine (Prozac) 10 mg along with 20 mg - signed 6/16/20. -6/16/20 - start date - Jarrow B Right (B complex) - 1 capsule in a.m. - signed 6/16/20. Record review on 11/16/20 of Client #5's MARs for May 2020 through October 2020 revealed: -Fluoxetine (Prozac) 10 mg along with 20 mg - started 6/18/20. -Jarrow B Right (B complex) - 1 capsule in am - started 6/18/20. Record review on 11/16/20 of Client #6's physician orders dated 4/13/20 through 10/30/20 revealed: -5/5/20 - start date - 5/5/20 - Pure Iron C every a.m. for 3 months - signed - 5/5/20 -5/5/20 - start date - Veeva Theanine & Magnesium B-vitamins - 1 capsule every a.m. signed 5/5/20. -8/10/20 - start date - Fluticasone Prop 50 mcg - 1 spray each nostril 1 time a day for a month - signed 8/10/20. Record review on 11/16/20 of Client #6's MARs for May 2020 through October 2020 revealed: -Pure Iron C every a.m. for 3 months - started 5/7/20. -Veeva Theanine & Magnesium B-vitamins - 1 capsule every a.m. - started 5/7/20. -Fluticasone Prop 50 mcg - use as directed - PRN - given 10 x August and 2 x September instead of daily for 1 month.	V 118		

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V 118	Continued From page 66 Record review on 11/16/20 of Client #7's physician orders dated May 2020 through October 2020 revealed: -5/4/20 - start date- Increase Spironolactone (Aldactone) 25 mg - to 1 tablet 2 times a day - signed 5/4/20. -5/4/20 - start date - Decrease Citracal + D - to 1 tablet 2 times a day - signed 5/4/20. -7/16/20 - start date -Methylphenidate ER (Concerta) 18 mg - 1 daily every a.m. signed 7/16/20. -8/6/20 - start date - D/c Concerta 18 mg - start Concerta 27 mg 1 every a.m. signed 8/10/20. -7/16/20 - start date - Trazodone (Desyrel) change to 25 mg every 6:00 p.m. - 10 p.m. PRN - signed 7/16/20. -5/4/20 - N-acetylcysteine 600 mg 2 times a day for 1 week - then 1200 mg 2 times a day - signed 5/4/20. -10/20/20 - start date - Ritalin to 10 mg - 1 tab daily at 3:00 p.m. - signed 10/20/20. Record review on 11/16/20 of Client #7's MARs for May 2020 through October 2020 revealed: -Spironolactone (Aldactone) 25 mg - 1 tablet 2 times a day - 5/8/20 blank with no exception documented. - Citracal + D - decreased to 1 tablet 2 times a day - not started until 5/6/20 - 5/8/20 blank with no exception documented. -Methylphenidate ER (Concerta) 18 mg - daily in a.m. - not started until 7/21/20. -Concerta - increase to 27 mg - not started until 8/10/20. -Trazodone (Desyrel) 50 mg - ½ tablet (25 mg) - 1 time a day - given daily (not PRN) from May 2020 through October 2020; PRN also listed and given as such one time on 9/24/20. -NAC - N-acetylcysteine 600 mg - 1 capsule 2 times a day - not started until 5/6/20; 5/8/20 was	V 118		

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blank with no exception documented.
-Ritalin 10 mg - 1 tab daily at 3:00 p.m. - not started until 10/22/20- 10/28/20, 10/30/20, and 10/31/20 were blank with no exception documented.

Record review on 11/16/20 of Client #8's physician orders dated 10/31/19 through 10/30/20 revealed:
-6/10/20 - start date - Bayer Womens One-a-day Multivitamin -1 every a.m.- signed 6/10/20.
-8/7/20 - start date - Duloxetine (Cymbalta) change to 40 mg every p.m. - signed 8/7/20

Record review on 11/16/20 of Client #8's MARs from May 2020 through October 2020 revealed:
-Bayer Womens One-a-day Multivitamin - 1 every a.m.- was not listed.
-Duloxetine (Cymbalta) increase to 40 mg every p.m. was not started until 8/11/20.

Record review on 11/16/20 of Client #9's physician orders dated 4/23/20 through 10/30/20 revealed:
-5/27/20 - start date - Pure Lithium Orotate - increase to 10 mg - 2 times a day- signed 5/27/20.
-7/14/20 - start date - Chaste Tree - 225 mg - 1 capsule every HS - signed 7/14/20.
-8/24/20 - start date - Klaire Labs Candida Complex - 1 capsule every a.m. - signed 8/24/20.
-10/30/20 - start date - Lamotriqine (Lamictal) - decrease to 50 mg - 2 times a day - signed 10/30/20.
-10/30/20 - start date - Magnesium Oxide 140 mg - 1 capsule after dinner - signed 10/30/20.

Record review on 11/16/20 of Client #9's MARs for May 2020 through October 2020 revealed:
-Pure Lithium Orotate 5 mg - 2 capsules (10 mg)

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after breakfast and dinner - 7/2/20 at 7:00 p.m. and 8/10/20 were blank with no exception documented.
-Pure Chaste Tree (Vitex) - 1 cap at HS - was not started until 8/4/20.
-Klaire Labs Candida Complex - 1 cap every a.m. - 8/26/20 through 8/31/20 had dashes with no exception documented.
- Lamotriqine (Lamictal) 100 mg - 1 tab 2 times a day - were given 10/30/20 and 10/31/20 instead of 50 mg.
-Magnesium Oxide 140 mg - 1 after dinner - was not listed starting 10/30/20 or 10/31/20.

Record review on 11/16/20 of Client #10's physician orders dated June 2020 through October 2020 revealed:
-7/3/20 - start date - Methylphenidate ER (Concerta) 27 mg - 1 tab every a.m. signed 7/3/20.
-7/30/20 - start date - Nature made Multivitamin for Her - 1 tab at HS - signed 7/30/20.
-9/8/20 - start date - Sertraline HCL (Zoloft) - decrease to 50 mg - 1 tablet daily - signed 9/8/20.

Record review on 11/16/20 of Client #10's MARs for June 2020 through October 2020 revealed:
-Methylphenidate ER (Concerta) 27 mg - 1 tablet every a.m. - was not started until 7/7/20.
- Nature made Multivitamin for Her - 1 tablet at HS - was not started until 8/3/20.
-Sertraline HCL (Zoloft) - decrease to 50 mg - 1 tablet daily - was not decreased until 9/10/20.

Record review on 11/16/20 of Client #11's physician orders dated July 2020 through October 2020 revealed:
- 7/13/20 - start date - Adderall XR 10 mg - change to 1 capsule every a.m. on school days - Monday through Thursday - signed 7/13/20

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V 118	Continued From page 69 (Monday). -7/13/20 - start dated - Amphetamine Salts (Adderall) 5 mg - change to 1 tablet at lunch on school days - Monday through Thursday- signed 7/13/20. -8/26/20 - start date - " ...Start Cymbalta 20 mg po q am for 15 days ..." - signed 8/26/20. Record review on 11/16/20 of Client #11's MARs for July 2020 through October 2020 revealed: -Adderall XR 10 mg - 1 cap every am on school days -was not started until 7/16/20. -Amphetamine Salts (Adderall) 5 mg - 1 tab at lunch time on school days - was not started until 7/15/20. -Duloxetine (Cymbalta) 20 mg - 1 cap Q am for 15 days - was not started until 8/28/20. Interview on 11/2/20 with Client #2 revealed: - her birth control medication had been given to her late one time. - she didn't get it until the afternoon hours. Interview on 11/2/20 with Client #3 revealed: - she may have missed a supplement about a month after she was admitted. -at times there was only one medication trained staff for multiple teams. Interview on 11/3/20 with Client #5 revealed: -one time a shipment of her sleep medication was late. -this occurred in April 2020 - she took it at 10:30 p.m. that night. Interview on 11/7/20 with Client #7 revealed: -medications had been late, but it was more on him than on the staff - he was too sad to get out of bed. -Trazadone was sometimes later but it was "no	V 118		

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V 118	Continued From page 70 big deal." -he had a new 3:00 p.m. medication and he and staff both forgot about it. -sometimes there was no trained staff to give the medications until later. Interview on 11/3/20 with Client #8 revealed: -she had missed 6:00 p.m. Cymbalta three times when she first started taking it. -last night there was not two medication trained staff for two teams like there usually was. Interview on 11/3/20 with Client #9 revealed: -no medications had been missed nor was a wrong dose given. -medications were "late sometimes." - she did not remember having received more of a medication than she was supposed to. -an alarm went off for the medication to be taken. Interviews on 11/3/20 and 11/17/20 with Nurse #1 and Nurse #2 revealed: -the physician orders were in the electronic medical record called "Blue Step." -the "Blue Step" system was supposed to automatically and electronically sign physician orders once they were entered. -an order without a physician signature would only occur if a verbal order was entered by a nurse and not yet signed by the doctor. -their policy states the physician had 14 days to sign verbal orders. -there was no alert system in "Blue Step" to flag new orders from the physician's screen. -in June 2020 they recognized this glitch and implemented an audit of all physician orders on a weekly basis so they could notify the doctor of any missing signatures for verbal orders. -the Registered Nurses (RNs) were responsible to review the orders and share with the	V 118		

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pharmacy.
-the pharmacy then reviewed the order and made changes to the MARs.
-any medication changes would usually be delivered that same day Monday - Friday; otherwise routine medications were delivered every 2 weeks on Tuesday.
-once the medication was delivered the RNs compared delivered medications with the MARs and approved them for implementation.
-the RN would do this as soon as they were back in the office, or Monday if the change occurred over the weekend.
-a weekly report was ran by the RNs to review any errors or holes in the MARs and an incident report would be required.
-when errors were found an "audit email" was sent to all "med givers" to notify them of errors and the need to do an incident report.
-if a medication was given outside the 90-minute window the initials on the MAR should be circled.
-if the medication was missed the MAR would be blank.
-the "med giver can" write an explanation as to why a medication was missed or late.

Review on 12/2/20 of the Plan of Protection dated 12/2/20 written by the Executive Director revealed:

"What immediate action will the facility take to ensure the safety of the consumers in your care?

1. In-service scheduled for Thursday, December 3, 2020 for med trained staff. How to properly indicate on the MARS that a med was missed or given and how to document Incident Reports for med trained staff.
2. Nurses will immediately begin a medication review worksheet (that will include the 5 rights)

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SOLSTICE EAST, LLC	530 UPPER FLAT CREEK ROAD WEAVERVILLE, NC 28787

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that will be a monthly recap to compare MARS versus orders that will begin tomorrow. MARS and Orders audit will be completed once per week beginning tomorrow.

Describe your plans to make sure the above happens (Each number correlates to above number.)

1. We will immediately begin to issue a test to each med trained individual on how to properly document on the MARS that a med was missed or given and how to document Incident Reports.
2. Worksheets will immediately become part of the CQI (Continuous Quality Improvement) process for auditing. Tracking and trending will be done weekly."

Review on 12/3/20 of the amended Plan of Protection dated 12/3/20 written by the Executive Director revealed:

What immediate action will the facility take to ensure the safety of the consumers in your care?
"Please note that many of the examples of missing orders cited are present in the facility records and will be
provided to DHSR auditors. Nonetheless, the below actions are being taken to continue to provide safe care to
our residents.
1. An in-service run by a registered nurse is scheduled for Thursday, December 3, 2020 for med-trained
staff covering the following topics:
a. How to properly indicate on the MAR that a med was missed or given
b. How to document med related incidents in incident reporting system
Registered nurse will administer a test based on

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the in-service training. Those who do not display proficiency will be re-educated and retrained by the registered nurse or qualified designee.
2. Registered nurse will begin a medication review worksheet as of December 3, 2020 that will include the
5 rights and compare MAR versus orders. This audit will also review changes in orders and timeliness of
signatures and implementation as well as tracking and trending. Worksheets will immediately become
part of the CQI (Continuous Quality Improvement) process for auditing. These reviews will be completed once per week for the next 30 days and ongoing until substantial compliance is achieved and
maintained as determined by the governing body.
Areas of Focus for Audits and Correction:
a. Comparison of incident report medication errors (late, refusals, missed) to MAR
i. Staff retraining on 12/3/20 for proper incident report procedure
ii. Weekly cross referencing of MAR to Incident Reports by Registered Nurses to ensure
data is complete and correct
b. Medications observed with no orders
i. A monthly recap starting 12/2/20 will be performed to ensure orders are up to date and in patient record
c. Medications not observed- have orders- do not have discontinuation orders
i. A monthly PRN medication clean up will be performed by contracted medical provider to review ongoing necessity of medication regimen and provide discontinuation as
necessary
ii. A monthly medication recap will identify any orders that are currently active on the MAR
but no medication is present at facility

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V 118	Continued From page 74 d. Medications listed on MAR- were not observed, did not find orders- nor discontinue orders i. A monthly recap starting 12/2/20 will be performed to ensure orders are up to date and in patient record ii. MAR and Orders audit will be completed once per week beginning 12/3/20 e. Administration of medication began before signed order (Solstice East policy states orders will be signed within 14 days) i. MAR and Orders audit will be completed once per week beginning 12/3/20 f. Medication changes/new medications not implemented immediately and no exceptions/ justifications documented on MAR i. Beginning 12/3/20, orders are reviewed and implemented by Registered Nurses. Contracted providers will notify Registered Nurses for urgent orders outside of business hours. In the event that a medication is not readily available from the contracted pharmacy, an order for temporary suspension will be obtained from the contracted provider. Describe your plans to make sure the above happens (Each number correlates to the above number.) 1. Operations director or qualified designee will audit the described tasks on a weekly basis for completion. 2. Operations director or qualified designee will audit the described tasks on a weekly basis for completion." This deficiency constitutes a re-cited deficiency. This residential facility serves adolescent females	V 118		

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V 118	Continued From page 75 ages 15-18 whose diagnoses included Major Depressive Disorder, Attention-Deficit Hyperactivity Disorder, Generalized Anxiety Disorder, Post-Traumatic Stress Disorder, Oppositional Defiant Disorder, other specified Trauma and Stressor Related Disorder and Parent Child Relational Problems. There were four clients who had medications administered without physician's orders and two clients had medications administered approximately 16 to 69 days before the order was signed by the physician. If there were new orders or changes in current orders these changes were not implemented until approximately two to 25 days later for ten clients. Seven clients had medications that had current orders that were not observed to be on hand. It was unable to be determined if the medications were available in the facility or if they were discontinued. Medication errors that were recorded on incident reports were not accurately recorded on the MARs. On the facility summary of incident reports there were five clients where the report reflected a medication was missed, late, or a wrong dose was given and the MAR was initialed by staff to appear it was administered as ordered. One of these clients continued refusal resulted in being admitted to the hospital. Four clients had MARs that were incomplete as there were blanks without justifications or explanations. The adolescents in this program were prescribed various psychotropic medications, among others, to help stabilize their conditions. It was unable to be determined if medications were given appropriately and created a clinical culture that was neglectful. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $3,000.00 is imposed. If the violation is not corrected within 23 days, an additional	V 118		

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V 118	Continued From page 76 administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 118		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. . This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to immediately notify the physician or pharmacist for drug administration errors and failed to properly record the errors in the clients' drug record affecting 6 of 11 current clients audited (Clients #4, #5, #6, #7, #8, and #9) and 1 of 7 Former Clients (FC #16) audited. The findings are: Review on 10/21/20 and 10/29/20 of Excel summary of incident reports provided by facility for all incidents from 3/28/20 - 10/23/20 revealed: -115 medication error reports (this report impacted clients outside the scope of the review). -of these, 44 medications were late and 71 medications were missed.	V 123	V123- Medication Requirements- Facility failed to immediately notify the physician or pharmacist for drug administration errors and failed to properly record the errors in the client's drug record. Solstice East's Governing Body reviewed Tag V123 and gave direction for the following corrections, preventative measures and ongoing monitoring to take place: Correction: A training was provided to med trained staff on 12/3/20, which included: 1. Review of medication error trends. 2. Review of tools in the eMAR to prevent missed medications and check for medication pass completion. 3. Proper incident report completion for medication related events. An incident report checklist was provided to med givers to reference when completing an IR for medication incidents. Checklist includes pertinent information that needs to be included in each incident report and clarifies previous points of confusion. 4. Review of patterns and mistakes identified during incident report audits. 5. When to contact the nurse or nurse on call for medication related questions or events. 6. Nurse on call should be notified immediately in the case of missed medication, or other medication related incident, so that nurse on call can notify provider or pharmacist of error. Daily audits implemented by registered nurses to review med pass completion and identify missed medications for timely notification of contracted physician or pharmacist. Prevention and Monitoring: Registered Nurse will provide monthly in-service for med givers to provide updates, identify new patterns, and refresh knowledge of policies and procedures.	

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V 123	Continued From page 77 -the name of the medication late or missed was not always listed (morning meds/pm meds). -medications included: Concerta ER, Clotrimazole topical, Lo Loestrin, Lillow 28, Clindamycin, Flonase nasal spray, Methylphenidate ER, Norethindrone, Lamotrigine, Aripiprazole, Gabapentin, Trileptal, Clonidine, Amphetamine Salts, Phenazopyridine, Betamethasone foam, Geodon, Propranolol, Prazosin, Nortriptyline, Spironolactone, multivitamin, fish oil, probiotic and other supplements and other unknown/undocumented medications. -3/28/20- Client #7 refused morning meds (unknown) and then staff forgot to give. Doctor notified 3/30/20. -4/18/20 - FC #16 refused 6:00 p.m. medications-fluvoxamine, propranolol and risperidone but decided to take them at 8:00 p.m. -nurse notified - Doctor notified 4/20/20. -4/21/20- Client #5 arrived with supply of medications-insurance not yet covering medications-ran out of prazosin missing 1 dose-client reported nightmares and poor sleep due to missing medication. Doctor notified 4/22/20. -4/30/20-Client #7 refused "pm med" because it had oil on it- Doctor notified 5/1/20. -5/1/20 through 5/6/20 Client #6's multivitamin was not available- Doctor was not notified until 5/2/20. -5/6/20 -Client #9 given 6 mg dose of Prazosin rather than 4 mg - Doctor notified 5/7/20. -5/10/20- Client #9 saccharomyces boulardii (supplement) not available - Doctor notified 5/11/20. -6/4/20- FC #16 initially refused but took "morning meds" late- Doctor notified 6/5/20. -6/10/20- Client #7- "6pm meds. student and staff forgot medication within window. Medications	V 123	Continued From page 77 Registered Nurse or qualified designee completes daily audit to review med pass completion and identify missed medications for timely notification of contracted physician or pharmacist. If audit shows missed medication, nurse on call will notify the contracted physician or pharmacist. Registered nurse or qualified designee performs weekly cross referencing of the eMAR to Incident Reports which includes: 1. Review of incident reports for medication related events (medication error, refusal, etc). 2. Review of eMAR documentation for accuracy and currency. 3. Comparison of eMAR documentation to incident report. Auditing will continue per above plans until substantial compliance is met and maintained as directed by the Governing Body.	

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were given shortly after medication window closed." -nurse approved-no documentation of doctor or pharmacist notification.
-6/23/20- Client #7 -"all AM meds" late -nurse approved- no documentation of doctor or pharmacist notification.
-7/15/20 Client #8 - dispenser of the medication was broken and client unable to obtain the foam from the bottle. Working with pharmacy and manufacturer for free replacement as the medication was over $200. This will be a several month process - client will miss for an unknown period of time. Guardians were aware - no evidence the doctor or pharmacist was notified.
-7/29/20 Client #4- pattern of medication resistance and refusal started the night of 7/29/20. She refused all 7:30 p.m. and 9:00 p.m. medications that evening. Client #4 refused morning medications on 7/30/20 but later agreed to take them around 11:00 a.m. She initially refused the night of 7/30/20 but agreed to take them at 9:30 p.m. On 7/31/20, Client #4 initially refused morning meds but agreed to take them around lunch time. She refused p.m. medications on 7/31/20. Client #4 continued to refuse her medications on 8/1/20 and 8/2/20 up until the time of hospitalization on 8/2/20. No indication of when doctor or pharmacist was notified of each refusal or late medication. Client was hospitalized on 8/2/20 due to refusals to eat/drink or take medications. (Refer to V112 for additional information.)
-8/4/20- Client #9- supplement (saccharomyces Boulardii) - pharmacy notified the facility that medication was on backorder resulting in the client missing the supplement until medication was delivered. No evidence doctor or pharmacist was notified. (8/24/20-Physician's order discontinued the supplement.)
-8/13/20 Client #4 - late-clonidine- contacted

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medical on call (RN) - no documentation of notification to doctor or pharmacist.

Interview on 10/23/20 with Nurse #1 revealed:
-staff always called the nurse when there was a problem with medications - then the nurse would call the doctor. Staff do not call the doctors.
-3 nurses rotate on call - "medical on call."
-Nurses complete follow-up on IRs (Incident Reports) - information was added after the fact.
-the staff did not realize they missed a medication- these errors were discovered in weekly audits of the MARs- will make edit note on the MAR and notes added to the exceptions.
-if staff missed a medication and realized it- they would reach out to the nurse on call/medical on call.
-"Supplements are usually given ok by nurse to give late."

Interview on 11/3/20 with Nurse #1 and Nurse #2 revealed:
-too much prazosin would cause sleepiness or dizziness- it was used to treat nightmares.
-staff completed their own IR and nurses followed-up after IR was written.
-expectations- "med giver" calls medical on call- "med giver" to complete IR prior to end of shift or within 24 hours.
-nurses review IRs and MARs weekly.
-EMR would show ERROR message for late administration- "med giver" calls medical on call-med giver can write explanation as to why late in EMR notes on last page of MAR in exceptions.
-If med giver had frequent issues- nurses could temporarily suspend and require retraining - annual recertifications were required for "med givers."
-there was frequent communication via the email

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V 123	Continued From page 80 distribution list. -new or tapered medications were communicated via email to the "med givers" of the clients specific team. -a "client error"- was documented as clients were held accountable to take their medications - but staff were responsible to administer medications. This deficiency is cross referenced into 10A NCAC 27G.0209(c) - Medication Requirements (V118) for a Type A1 and must be corrected within 23 days.	V 123		
V 364	G.S. 122C- 62 Additional Rights in 24 Hour Facilities § 122C-62. Additional Rights in 24-Hour Facilities. (a) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-61, each adult client who is receiving treatment or habilitation in a 24-hour facility keeps the right to: (1) Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary; (2) Contact and consult with, at his own expense and at no cost to the facility, legal counsel, private physicians, and private mental health, developmental disabilities, or substance abuse professionals of his choice; and (3) Contact and consult with a client advocate if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each adult client may exercise these rights at all reasonable times. (b) Except as provided in subsections (e) and (h) of this section, each adult client who is receiving treatment or habilitation in a 24-hour facility at all times keeps the right to:	V 364	V364: Additional Rights in 24-Hour Facilities: Facility failed to ensure each minor client who received treatment in a 24-hour facility had the right to communicate and consult with her legal guardian(s). Solstice East's Governing Body reviewed Tag V364 and gave direction for the following corrections, prevention measures and ongoing monitoring to take place: Correction: Clinical in-service held on 12/07/2020 instructed that clients take part in family therapy sessions each week of their enrollment in the program. Any variance from this expectation will be considered a restriction of rights and therefore authorized by the Qualified Professional responsible for for the formulation of the client's treatment plan. Restrictions are reviewed every 7 days for removal (not to exceed 30 days). Documentation of such restrictions (including the detailed reason for the restriction) will be placed in the client's record. Parent Handbook has been updated to read: "Your daughter will begin making social phone calls to you after the therapist gives approval that your daughter and you are ready. This is determined during the process of family therapy which begins within the first week of your child's enrollment. The primary factor in this decision is the emotional state of your daughter and her readiness to have a productive call with you. Often girls can be quite angry about her admission to the program and if they have not processed through this well enough, the first phone call can be negative and hurtful ..."	

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V 364	Continued From page 81 (1) Make and receive confidential telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over therapies; (3) Communicate and meet under appropriate supervision with individuals of his own choice upon the consent of the individuals; (4) Make visits outside the custody of the facility unless: a. Commitment proceedings were initiated as the result of the client's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found not guilty by reason of insanity or incapable of proceeding; b. The client was voluntarily admitted or committed to the facility while under order of commitment to a correctional facility of the Division of Adult Correction of the Department of Public Safety; or c. The client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; A court order may expressly authorize visits otherwise prohibited by the existence of the conditions prescribed by this subdivision; (5) Be out of doors daily and have access to facilities and equipment for physical exercise several times a week; (6) Except as prohibited by law, keep and use personal clothing and possessions, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Keep and spend a reasonable sum of his	V 364	Continued From page 81 Prevention and Monitoring: Clinical Director, or qualified designee, performs weekly audit of client charts to assess: client's participation in weekly family therapy calls beginning within the first week of enrollment and accurate and complete documentation of any variance from this expectation. Action plans, to include retraining and/or disciplinary action, will be documented where deficiencies are noted. Operations Director, or qualified designee, performs weekly secondary audits of client charts to confirm: client's participation in weekly family therapy calls beginning within the first week of enrollment and accurate and complete documentation of any variance from this expectation. Clinical Director is informed of deficiencies and corrections are made. A pattern of nonadherence to policy will lead to progressive disciplinary action(s), issued by the Clinical Director, or qualified designee. Auditing will continue per above plans until substantial compliance is met and maintained as directed by the Governing Body.	

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V 364	Continued From page 82 own money; (9) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes; and (10) Have access to individual storage space for his private use. (c) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-57 and G.S. 122C-59 through G.S. 122C-61, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to have access to proper adult supervision and guidance. In recognition of the minor's status as a developing individual, the minor shall be provided opportunities to enable him to mature physically, emotionally, intellectually, socially, and vocationally. In view of the physical, emotional, and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate structure, supervision and control consistent with the rights given to the minor pursuant to this Part. The facility shall also, where practical, make reasonable efforts to ensure that each minor client receives treatment apart and separate from adult clients unless the treatment needs of the minor client dictate otherwise. Each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to: (1) Communicate and consult with his parents or guardian or the agency or individual having legal custody of him; (2) Contact and consult with, at his own expense or that of his legally responsible person and at no cost to the facility, legal counsel, private physicians, private mental health, developmental disabilities, or substance abuse professionals, of his or his legally responsible person's choice; and (3) Contact and consult with a client advocate, if there is a client advocate.	V 364		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 364	Continued From page 83 The rights specified in this subsection may not be restricted by the facility and each minor client may exercise these rights at all reasonable times. (d) Except as provided in subsections (e) and (h) of this section, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to: (1) Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Send and receive mail and have access to writing materials, postage, and staff assistance when necessary; (3) Under appropriate supervision, receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over school or therapies; (4) Receive special education and vocational training in accordance with federal and State law; (5) Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with his needs; (6) Except as prohibited by law, keep and use personal clothing and possessions under appropriate supervision, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Have access to individual storage space for the safekeeping of personal belongings; (9) Have access to and spend a reasonable sum of his own money; and (10) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes. (e) No right enumerated in subsections (b) or (d) of this section may be limited or restricted except	V 364		

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V 364	Continued From page 84 by the qualified professional responsible for the formulation of the client's treatment or habilitation plan. A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional at least every seven days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's record. Restrictions on rights may be renewed only by a written statement entered by the qualified professional in the client's record that states the reason for the renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal of a restriction of rights, an individual designated by the client shall, upon the consent of the client, be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction or renewal of a restriction of rights and of the reason for it. Notification of the designated individual or legally responsible person shall be documented in writing in the client's record. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure each minor client who received treatment in a 24-hour facility had the right to communicate and consult with her legal	V 364		

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guardian(s) for 11 of 11 current audited clients (Client #1, Client #2, Client #3, Client #4, Client #5, Client #6, Client #7, Client #8, Client #9, Client #10 and Client #11) and for 7 of 7 former audited clients (FC #12, FC #13, FC #14, FC #15, FC #16, FC #17, FC #18). The findings are:

Refer to tag V112 and V522 for additional information.

Review on 10/5/20 of Student Handbook revealed:
-The facility programming was based on the Hero's Journey or phase program. The phases include:

-Orientation- basic understanding of program rules/requirements. Restrictions included: must stay within arm's length of staff, no makeup/jewelry/iPod, may not have unsupervised conversation with girls on initiation or lower, no social calls.

-Separation-complete all phase assignments, basic cooperation. Restrictions included: must be within 10 feet and in line of sight of staff at all times, no jewelry/makeup, may not have unsupervised conversations with other girls on Separation or Threshold, cannot go off campus for any reason without therapist's approval, no social calls.

-Threshold-"jumping off point"-can have 1-20 minute phone call with parents during designated time per week. Restriction includes-may not have unsupervised conversation with other girls on Separation or Threshold.

-Initiation-occasionally slips into old behaviors, manages emotions appropriately most of the time, beginning to accept responsibility for past, present, future actions. May have unsupervised conversation with girls on all phases. May make 1- 25 minute phone call with

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parents. Restriction includes- may not hang out in room alone.

-Transformation- revelation- accepts responsibility, strong role model for peers, working diligently on family issues and all therapy. May have unsupervised time with staff permission. May have 1-30 minute call or 2 calls (total 30 minutes) to parents and other approved family members.

-Atonement- high level of trust from peers and staff, displays good judgement in most decisions, motivated by internal goals as opposed to external. May have up to 2 hours unsupervised time per week, on or off campus. May have 60 mins of phone calls (30 minutes to family and 30 minutes to anyone on approved phone call list.) per week at any time at staff convenience.

-Return-return to everyday life with new skills and awareness. May have up to 3 hours unsupervised time but no more than 6 hours per week.

-each phase had increased expectations and privileges clearly described in the handbook. Each phase had written assignments which also required completion before moving to the next phase.

-the Codes of Conduct, also in the Student Handbook outlined expectations with hygiene, dress and grooming as well as physical and emotional safety under the Safety Code. Violations of the safety code resulted in a client being placed on 'Safety Phase" and resulted in consequences and stepping out of their current phase.

-the treatment team made a final determination whether a client returned to their previous phase or was stepped down in their treatment phase.

Review on 10/22/20 of Phone Call Policy from the

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V 364	Continued From page 87 Parent Handbook revealed: -"Your daughter will begin making phone calls to you on a weekly basis within the first couple of weeks following admission. Phone calls begin after the therapist gives approval that your daughter and you are ready. This is generally determined during the process of the first family therapy session which usually also occurs within the first week or two. The primary factor in this decision is the emotional state of your daughter and her readiness to have a productive call with you. Often girls can be quite angry about her admission to the program and if they have not processed through this well enough, the first phone call can be negative and hurtful ..." Record review on 10/8/20 for Client #1 revealed: -Admission date- 8/19/20 -Age 14 years -Diagnoses: Parent-Child Relational Disorder, Generalized Anxiety Disorder (GAD), Attention-Deficit Hyperactivity Disorder (ADHD), and Major Depressive Disorder; -8/25/20 and 9/3/20 written family therapy notes did not indicate the client was present in these sessions with the therapist. The notes documented discussions between her therapist and her guardian about history, treatment goals and treatment process, and preparation for the 1st family session; -9/8/20, 9/17/20 and 9/24/20 family therapy notes documented Client #1's presence and participation; -in the 9/24/20 family session note, Client #1 was noted by the therapist to be focused on how anxious she was to talk with her parents on the phone and how she was working on the next treatment phase to be able to call her parents. -there was no documentation in the treatment plan/record regarding a reason for the restriction	V 364		

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and a review by the QP (qualified professional) every 7 days.

Record review on 10/9/20 for Client #3 revealed:
-Admission date- 5/11/20
-Age 15 years
-Diagnoses: Major Depressive Disorder, ADHD and GAD;
-a written family therapy note dated 5/18/20 identified the client was absent in this session while her parents and her therapist discussed treatment and program expectations for the client and family;
-a 5/26/20 family therapy note documented Client #3 was provided a 60-minute social call (2 weeks after her admission) with her parents at the end of the session and identified her topics of conversation with her parents ;
-a 6/10/20 written individual therapy note included her discussion with her therapist for a 1st social call with her parents outside a therapy session.
-there was no documentation in the treatment plan/record regarding a reason for the restriction and a review by the QP every 7 days.

Record review on 10/22/20 for Client #8 revealed:
-Admission date-10/31/19
-Age 16 years
-Diagnoses: Adjustment Disorder, Oppositional Defiant Disorder (ODD), Major Depressive Disorder, and Cannabis Use Disorder;
-a 8/31/20 written individual therapy note that documented she met with Client #8 after her hospital discharge on 8/29/20, stepped her down to the program's initial treatment phase of "Orientation," (which is 1 of the first two phases that by written facility program policy, restricted client telephone calls), explained expectations and kept the conversation to a minimum;
-a 9/1/20 written family therapy note identified

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V 364	Continued From page 89 Client #8 was absent from the session, followed by no family therapy session until 3 weeks later on 9/22/20. -there was no documentation in the treatment plan/record regarding a reason for the restriction and a review by the QP every 7 days. Record review on 10/16/20 for Client #10 revealed: -Admission date-6/8/20 -Age 17 years -Diagnoses: Other Specified Trauma-and-Stressor Related Disorder, Parent-Child Relational Problem, and ADHD; -6/9/20 and 6/16/20 written individual therapy notes documented she reported feelings of sadness in her difficulty with transitioning to facility and she felt angry about being restricted by the program rules and expectations; -6/12/20 and 6/18/20 written family therapy notes identified she was absent from both sessions. The notes indicated the sessions were discussions between the therapist and the parents about the weekly family therapy schedule, treatment goals and process; -a 6/25/20 family therapy note documented Client #10's presence and participation in the session, which was 2 weeks after her admission. -there was no documentation in the treatment plan/record regarding a reason for the restriction and a review by the QP every 7 days. Record review on 10/21/20 for Client #11 revealed: -Admission date- 7/7/20 -Age 17 years -Diagnoses: Post-Traumatic Stress Disorder, Persistent Depressive Disorder, ADHD, GAD, and Parent-Child Relational Problem; -a 7/13/20 written family therapy note identified	V 364		

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V 364	Continued From page 90 she was absent from this session. The session note indicated the therapist and parents explored family dynamics, family relationships, further history of treatment and goals for treatment. -there was no documentation in the treatment plan/record regarding a reason for the restriction and a review by the QP every 7 days. Interviews on 11/2/20 and 11/3/20 with Client #1, Client #2, Client #3, Client #5, Client #6, Client #7, Client #8, Client #9 and Client #10 revealed: -they were not allowed to make telephone calls to their parents during the first 2 treatment phases of the program, which were known as Orientation and Separation Phases; -a client remained in these 2 phases for about 2 weeks from the date of admission to about 2 months- their time in these phases depended on the length it took to learn the program rules and expectations, complete their phase assignments, and they had to show cooperation with their peers and staff as a team; -their therapist decided whether they stepped up in their treatment phase and gained privileges or were stepped down in phases; -the 1st two phases, they talked with their parents in family therapy sessions but the conversations were for therapy and were not "social" calls; -the 3rd treatment phase (Threshold) was the point at which they were allowed to make a 20-minute telephone call once a week to their family; -telephone calls to family members were made in a group room located in the basement of the facility with 3 or 4 other peers who called and talked with their families; -their telephone calls were monitored by staff; -when placed on "Safety" or "Safety Precautions" (interventions such as a client placed on arm's length supervision by staff, completing	V 364		

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V 364	Continued From page 91 behavior-focused assignments from therapist, sleeping in common area), they were not allowed to call their family. Their therapist called their family; -the higher they got in their treatment phases such as "Transformation" (30-minute telephone calls during designated times) and Atonement," (60-minute calls), the longer in length and with more frequent their telephone calls were allowed by staff; -telephone call privileges were lost or reduced when a client was stepped down in their treatment phase or when placed on safety or safety precautions. Interview on 11/9/20 with Client #5's guardian revealed: -she understood client privileges were based on their treatment phases. When her daughter first arrived at the facility, there was a period she did not call home until she moved into another treatment phase; -if a client were placed on safety, no phone calls were made home but she and her daughter have continued to have weekly calls. Interview on 10/6/20 with Counselor #2 revealed: -when a client was placed on Safety Phase, the client did not attend their family therapy sessions until after they were removed from this phase and their experience on safety had been processed with the resident peer council and treatment team. Interview on 12/1/20 with management staff who included the Founder, Executive Director (ED), Operations Director, Clinical Director, and Program Director revealed: -the Founder indicated the facility had not violated client rights to communicate with their parents;	V 364		

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V 364	Continued From page 92 -clients were allowed to communicate with their parents during their family therapy session which was held in the first 2 weeks after a client's admission. This deficiency is cross referenced into 10A NCAC 27E .0101 Least Restrictive Alternative (V513) for a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 364		
V 513	27E .0101 Client Rights - Least Restictive Alternative 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports that promote a safe and respectful environment. These include: (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include: (1) using the intervention as a last resort; and (2) employing the intervention by people trained in its use.	V 513	V513: Least Restrictive Alternative: Facility failed to design services and supports that ensured the use of the least restrictive intervention methods to maintain client dignity and respect to the clients served. Solstice East's Governing Body reviewed Tag V513 and gave direction for the following corrections, preventative measures and ongoing monitoring to take place: Correction: Safety Phase Policy updated to reflect a less restrictive intervention method, including the following revisions: 1. Removal of following expectation: "Student will present an oral report to their team on principles related to the safety code they violated." 2. Removal of the expectation to: "Seek feedback from resident council" unless such feedback can be documented and is clinically indicated, such that it provides client support, practice in interpersonal effectiveness, and progress toward established treatment goals 3. Revision that the expectation for building restrictions are now options only used when clinically indicated for purposes of the client's safety 4. Sleep observation may be utilized when clinically indicated for the purpose of the client's safety or safety of others but is no longer mandatory. 5. Revision of communication block to communication focus with expectation that communication be primarily focused on safety assignments with redirection as necessary to achieve progress on treatment goals	

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V 513	Continued From page 93 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to design services and supports that ensured the use of the least restrictive intervention methods to maintain client dignity and respect to the clients served effecting 11 of 11 current audited clients (Client #1, Client #2, Client #3, Client #4, Client #5, Client #6, Client #7, Client #8, Client #9, Client #10, and Client #11) and 7 of 7 former audited clients (FC #12, #12, #14, #15, #16, #17, #18). The findings are: CROSS REFERENCE: 10A NCAC 27G .0201 Governing Body Policies (V105) Based on record reviews and interviews, the governing body failed to develop and implement standards of practice that assured compliance with clients' written discharge for 1 of 11 current audited clients (Client #4) and for 4 of 7 former audited clients (FC #12, FC #13, FC #14, and FC #18). The facility's governing body failed to ensure their reporting incident system was followed to identify trends and patterns for solving problem issues in client care and services for 5 of 11 current audited clients (Client #3, Client #4, Client #5, Client #8, and Client #9) and for 1 of 7 former audited clients (FC #15). CROSS REFERENCE: 10A NCAC 27G.0205(c) Assessment and Treatment/Habilitation or Service Plan (V112) Based on record review and interviews, the facility failed to develop and implement treatment strategies for 7 of 11 current audited clients (Client #2, Client #3, Client #4, Client #5, Client #6, Client #8, and Client #10) and 2 of 7 former audited clients (FC #12, FC #14). The facility failed to ensure each treatment plan was developed with the client's legally responsible	V 513	Continued From page 93 In-service trainings addressed the use and documentation of least restrictive interventions and alternatives: 1. Clinical staff on 12/7/20: a. Expectations to assess for client physical and emotional well-being b. Updating treatment plans to reflect goals and strategies to address clients who had behaviors including AWOL, Self-Harm, Medication Refusals c. Adding goals to account for continued interventions d. Incorporation of assessment information contained in psychological evaluations 2. Residential staff on 12/15/20 Implemented Restrictive Intervention Report to be completed by on-call supervisor, or qualified designee, when RI is utilized, which includes attempted use of less restrictive alternatives. Prevention and Monitoring: Weekly audits to monitor and prevent deficiencies in the use of least restrictive alternatives focused on the following topics: 1. Incident reports (including use of RI) by Program Director or qualified designee. 2. Interventions and safety phase by Clinical Director or qualified designee. Audit will track and trend for: a. Missing data b. Patterns of psychoeducational training opportunities c. Ineffective or concerning intervention patterns d. Failure to utilize least restrictive alternatives e. Interference with client rights 3. Restrictive or non-traditional interventions by Clinical Director or qualified designee to verify that interventions were approved by treatment team 4. Completion of new MTPs by Clinical Director or qualified designee for compliance with policy regarding: a. Goals and strategies b. Use of Safety Phase protocol, if applicable c. AWOL, Self-Harm, Medication Refusals, if applicable d. Involvement of legally responsible person and signatures for verification of involvement 5. Shift notes by Program Director or qualified designee	

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V 513	Continued From page 94 person for 4 of 11 current audited clients (Client #2, Client #4, Client #5, and Client #6) and for 6 of 7 former audited clients (FC #12, FC #13, FC #14, FC #15, FC #16, FC#18). CROSS REFERENCE: NCGS§ 122C-62(c)(1) Additional Rights in 24-hour Facilities (V364) Based on record review and interviews, the facility failed to ensure each minor client who received treatment in a 24-hour facility had the right to communicate and consult with her legal guardian(s) for 11 of 11 current audited clients (Client #1, Client #2, Client #3, Client #4, Client #5, Client #6, Client #7, Client #8, Client #9, Client #10 and Client #11) and for 7 of 7 former audited clients (FC #12, FC #13, FC #14, FC #15, FC #16, FC #17, FC #18). CROSS REFERENCE: 10A NCAC 27E .0104 (9) (F) Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V521) Based on record reviews and interviews, the facility failed to ensure each client's restrictive intervention (RI) was followed by adequate documentation of a debriefing of each client RI incident for 4 of 11 current audited clients (Client #3, Client #4, Client #5 and Client #9) and for 2 of 7 former audited clients (FC #15, FC #18). CROSS REFERENCE: 10A NCAC 27E .0104 (10) Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V522) Based on record review and interviews, the facility failed to ensure each client with a restrictive intervention (RI) of more than 15 minutes had verbal and written authorization, as well as, a physical and mental well-being assessment by a qualified professional that	V 513	Continued From page 94 6. Secondary review of restrictive intervention audits by Executive Director or qualified designee If deficiencies are noted in the above audits, the following action plans will be implemented until substantial compliance is achieved as determined by the Governing Body: 1. Performance evaluations of staff 2. Identified and continued training of staff 3. Documentation of in-services provided or plan for improvement Quarterly (or as needed, defined by the governing body) audits by the Governing Body focused on the use and trends of restrictive interventions will: 1. assess for intervention effectiveness, measured by progress toward treatment team goals and decreased need for restrictive interventions or ongoing precautions 2. create an action plan specific to each trend. Department manager or qualified designee will carry out the plan of correction quarterly (or as needed, defined by the governing body). Auditing will continue per above plans until substantial compliance is met and maintained as directed by the Governing Body.	

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V 513	Continued From page 95 extended the RI for 2 of 11 current audited clients (Client #4 and Client #5) and for 3 of 7 former audited clients (FC #15, FC #16, FC #18). CROSS REFERENCE: 10A NCAC 27E .0104 (10) Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (16) (B) (V524) Based on record reviews and interviews, the facility failed to notify the legally responsible person of minor clients immediately when a restrictive intervention was utilized for 3 of 11 current audited clients (Client #4, Client #5 and Client #9) and for 1 of 7 former audited clients (FC #16). CROSS REFERENCE: 10A NCAC 27F .0102 Living Environment (V539) Based on record review and interview and interview, the facility failed to provide an atmosphere conducive to uninterrupted sleep during scheduled sleep hours for 6 of 11 current audited clients (Client #3, #4, #5, #8, #9, #10) and for 2 of 7 former audited clients (FC #13, FC #14). The findings are: Review on 10/9/20 of the facility's written Safety Phase policy 4.3 and dated August 2018 revealed: -Safety phase was an intervention designed for clients who demonstrated behaviors that were deemed by the facility to be physically and emotionally unsafe for all clients and staff and included but were not limited to: -any act of violence towards another person; -any threat or implied threat of violence, verbal or physical; -sexual acting out (kissing, touching another person, inappropriate conversations, sexual jokes).	V 513		

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V 513	Continued From page 96 -A therapist or licensed therapist authorized the approval for a client to be placed on Safety. -Staff were responsible to inform the client of the placement on Safety Phase and educate the client about the consequences, limitations and expectations. -This phase had a time range that client restrictions lasted from 18 to 72 hours. If an extension was needed, a client's therapist was required to document clinical justification for the extension in the client's case notes. -A client was kept in staff sight by being placed at arm's length with staff for the duration a client was on safety phase. -During the night shift, a client might be required to sleep on their mattress in the hallway or in the den (common area) to be maintained in staff sight. -A client on Safety was expected to complete all requirements of the phase to be returned to their previous treatment phase. -Expectations of the Safety phase included not were not limited to: -completion of a written safety phase assignment focused on understanding the impact of their behavior on others; -completion of written apologies to those affected by their unsafe behavior(s); -presentation of an oral report to their team on the principles related to the safety (behavior) code they violated; -completion of a service project related to the safety code they violated; -presentation of their safety phase assignment to a resident (peer) council where they were required to report what they have learned from the experience being on safety and seek feedback from the resident council. The council was expected to give feedback to the client's treatment team about whether the client	V 513		

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completed their assignments and was ready to return to their phase;
-a treatment team made a final determination whether a client returned to their previous phase or was stepped down in their treatment phase.

Record review on 11/7/20 for Client #8 revealed:
-an admission date of 10/31/19, age 16 years, and diagnosed with Adjustment Disorder, Oppositional Defiant Disorder (ODD), Major Depressive Disorder, and Cannabis Use Disorder.
-a 4/2/20 entry in her 3/13/20 treatment plan noted by her therapist (Counselor #3) indicated she was placed on Safety Phase for "inappropriate" behaviors with peers (sexually acted out);
-a 6/2/20 note added to her plan by Counselor #3 indicated she met with Client #8 and explained how her actions kept her on Safety Phase "longer than necessary."
-There was a lack of documentation which made it difficult to determine whether she was removed from her 4/2/20 placement on the Safety Phase.

Review on 11/7/20 of a written facility incident report for Client #8 revealed:
-on 8/27/20, she reported in a written team intervention assignment that she and a peer (Client #19) had touched each other inappropriately at night in their bedroom. She was on safety at the time and both Client #8 and Client #19 were placed on safety phase as determined by their therapists.

Review on 11/9/20 of a printed,13-page staff shift note dated 8/28/20 revealed:
-the note included the clients and staff on duty on Client #8's residential team and began with the 8/28/20 morning shift;

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-the printed note included electronic entries and did not identify a specific staff's name or position for each note entered;
-client names with their safety status and effective date placed on safety revealed:
-8/24/20, Client #8 was on safety, which required her to be arm's length from staff, her phase privileges suspended, CNC (bathroom door was cracked and student is counting to maintain communication with staff at the door), safety work assignments, communication restriction (Com-Bloc-no talking except to staff for personal needs), and sleeping in the (facility) common area;
-8/25/20, Client #19 was on safety and had same safety conditions as Client #8;
-clients who were on Safety Phase met with a resident council to present their individual safety phase assignments for council feedback recommendation to the treatment team to determine whether a client remained on Safety or was removed.
-Client #19 became emotional (teary) when she read her accountability letter that included her inappropriate relationship with Client #8. When the therapists (unnamed in the note entry) asked her questions, she kept saying she did not know what they wanted from her. "They" told her she was not taking accountability for everything. The note stated Client #19 "appeared confused and upset." She asked Staff #17 permission to go to her room as Client #8 read her letter. She explained her crying would distract from the group. Her request was denied by Staff #17 who told her " ...she needed to sit through the discomfort and realize her feelings." The therapists told her she needed more time to sit and reflect. Client #19 cried.
-After Client #19 shared her letter, Client #8 read her accountability letter which included multiple

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"inappropriate" behaviors with peers, her relationship with Client #19, and her manipulation of staff. Staff shared how they were impacted by Client #19's behaviors and she "broke down" when her therapist (Counselor #3) talked to her. After this group meeting, Client #8 continued to be emotionally upset and was unable to calm herself down with staff assistance to help her regulate.

Review on 11/9/20 of a printed 9-page staff shift note dated 8/28/20 revealed:
-the shift note was electronic and was indicated for the evening (PM) shift on 8/28/20.
-Client #8 and Client #19 remained on their Safety Phase.
-an individual note entry for Client #8 revealed:
  -she was given a list of 5 options she could choose from and was required to use her finger to communicate her needs to the staff;
  -she asked for supplies from her bedroom and she accessed a metal dental scalpel which she indicated she needed to clean her retainer. This item was removed from her by Staff #36.
-During the dinner meal, Client #8 cried and held up her finger which indicated she was in crisis ..."She said she wanted to die." She missed her dinner meal from being overwhelmed by emotion and 2 suicide risk assessments (SRAs) were completed with her by Staff #36. Client #8 was noted in this staff's entry as "feeling suicidal with no plan but a desire to make one, to in and out of suicidal thinking."
  -she was put on "snaps and sweeps" (student was required to pull or snap their bra and underwear for any possible contraband to fall out and a sweep of client area was removing objects with which they could self-harm) and "cracked and counting" (bathroom door was cracked and student is counting to maintain communication

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with staff at the door) to be kept safe.

Review on 11/7/20 of an incident report for Client #8 dated 8/29/20 at 2:48 pm revealed:
-she told Staff #9 she went into the bathroom and swallowed 2 detergent pods. Client #8 was taken to a local hospital emergency department and a blood test was done. No traces of the detergent were detected in her body, she showed no symptoms of poisoning, and she was returned to the facility the same day. She was already on Safety Phase at the time of this incident. No one at the facility witnessed her swallow the detergent pods.

Interview on 11/3/20 with Client #8 revealed:
-she had been at the facility a year and had gotten to the Atonement Phase (next to last phase of treatment) when she restarted her treatment-she was phased down after she was placed on Safety Phase and went to the hospital in 8/2020;
-she initially indicated her hospital emergency room visit could have resulted from a medication side effect (she had started a new medication for depression and anxiety before her home visit) or her behaviors while she was on a home visit;
-she later explained she went to the hospital after she and a peer who included Client #19 who were on Safety were "roasted" (3 peers were allowed to "interrogate" with questions in front of the team and talk "s**t about you" in front of the team);
-during this roasting, her therapist (Counselor #3) said she was going to turn out like her mother with her negative core beliefs, and she cried and self-harmed because she could not handle what her therapist said;
-at the hospital, she asked to talk to her family and was told to wait until Monday morning when she had a family therapy session;

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-her family therapy session did not occur the following Monday, 8/31/20;
-her therapist met with her Monday afternoon and phased her down to restart the program.

Interview on 11/23/20 with Client #19 revealed:
-in 8/2020, Client #8 shared her accountability letter during a team intervention;
-Counselor #3 said to Client #8, "if this is how you want to end up (like your mom), don't show up for this intervention."
-clients did not usually have to share accountability letters but Client #8 had to share hers;

-Client #8 said "[Client #19] assaulted" her and her team felt afraid of her and unsafe because of this statement.
-she was placed on "Comm block safety" and was not able to process (Client #8's statements) for a week. She was told to stop deflecting and given more assignments.
-after she was taken off safety, she was allowed to process the situation with her Counselor.

Interview on 11/7/20 with Counselor #3 revealed:
-Client #8 was in the 2nd to the last phase of her treatment program when she went on a home visit over the summer for 2 weeks and returned to the facility with "major regression" (told stories of self-harm and a sexual assault by a stranger while on leave, and pressured peers to act out sexually with her when she returned).
-her phase was decreased, her treatment was "restarted from scratch," and an updated psychological testing and assessment were obtained to determine her diagnoses and needs.
-Client #8 was on Safety Phase after she went to the hospital. When she went to safety (peer) council where she shared her thoughts, principles

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and values during her time on safety, other clients questioned her-held her accountable. She became "rigid and locked up," "tearful," and the group ended.
-she acknowledged she told Client #8 she was going to be like her mother but within a therapeutic context of confrontation of her (Client #8)'s fear;
-she did not document all the times she checked in with staff to see what behaviors they saw with Client #8 although she stated there were a lot of emails, texts and in-person communications about her;
-"[Client #8] lied so much she (Counselor #3) had to check in with staff first."

Review on 12/2/20 of an initial Plan of Protection dated 12/2/20 and signed by the Executive Director revealed:
What immediate action will the facility take to ensure the safety of the consumers in your care?
"1. 10A NCAC 27G.0201 Governing Body Policies (v105): Discharge report audits will be done weekly (starting 12/2) by the Clinical Director or designee. Incident report in-service training how to properly complete an Incident Report- scheduled for December 15, 2020. Incident reports will be reviewed weekly for completeness and accuracy by Operations Directors or designee beginning 12/2/2020. Incident report review by governing body for trends to begin 12/3/2020.
2.10A NCAC 27G.0205(c) Assessment and Treatment/Habilitation or Service Plan: Ongoing regular audits for master treatment plans to immediately include client specific goals and strategies, as well as signatures, completed by Clinical Director or designee.
3.122C-62 Additional Rights in 24-hour facilities (v364): [Surveyor #1] is immediately checking

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V 513	Continued From page 103 with DHSR to understand if supervised call with therapist suffices for this rule. 4.Restrictive Interventions a.10A NCAC 27E.0104(e)(9) Seclusion, Physical Restraint and Isolation Time-out and Protective Devices used for Behavioral Control (v521); Immediate in-service with on-call support staff on the role of student debriefing after a restrictive intervention and follow through. b.10A NCAC 27E.0104(e)(10) Seclusion, Physical Restraint and Isolation Time-out and Protective Devices used for Behavioral Control (v522); Immediate in-service with on-call support staff on the role in continued authorizations of restrictive interventions lasting longer than 15 minutes. c.10A NCAC 27E.0104(e)(16)(B) Seclusion, Physical Restraint and Isolation Time-out and Protective Devices used for Behavioral Control (v524): Immediate in-service with on-call support staff to complete documentation of parent notification on Incident Reports when necessary. 5.10A NCAC 27F.0102 Living Environment (v539): This is being discussed and possibly reviewed with a waiver for safety reasons. We will immediately provide students with sleeping masks and earplugs to reduce light and noise for better sleeping." Describe your plans to make sure the above happens (Each number correlates to the above number.) "1. 27G.0201 We will be beginning immediately to have discharge audits review, track and trend. Based on tracking and trending results, more specific education and in-service will be offered. We will issue a test to everyone at the in-service training to understand the directives and content of Incident reporting. Mentors who do not understand based on test results, will immediately be re-educated and retrained by the Residential	V 513		

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V 513	Continued From page 104 Director or qualified designee. 2. Clinical Director or designee will immediately begin to track and trend audits weekly for any missing data, patterns or education needs and patterns and needs will be immediately addressed. 3. Waiting on [Surveyor #1's] response - to be determined. 4. Interventions a. We will immediately begin to issue a test to each of the on-call staff to understand student debriefing. Residential Director or designee will audit Incident reports for student debriefing. b. We will immediately begin to issue a test to each of the on-call staff to provide ongoing authorizations for restrictive interventions longer than 15 minutes. c. We will immediately begin to issue a test to each of the on-call staff about documentation. Residential Director or designee will audit Incident reports for parent contact. 5. Residential Director or qualified designee will immediately begin to supply inventory of goods for mentor staff to issue to students." Review on 12/3/20 of a 2nd and an amended Plan of Protection dated 12/3/20 and signed by the Executive Director revealed: -this amended plan was completed by the facility's Founder, Executive Director, Operations Director, Clinical Director, and Assistant Clinical Director. What immediate action will the facility take to ensure the safety of the consumers in your care? "1.10A NCAC 27G.0201 Governing Body Policies (v105): The following will occur for the next 30 days and ongoing until substantial compliance is achieved and maintained as determined by the governing body: a. Discharge summary (DS) audits will be done	V 513		

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weekly (starting 12/2) by the Clinical Director or qualified designee. In addition, on 12/3/2020, the Clinical Director sent a calendar invite to the primary therapist for each client with confirmed discharge dates in December as a reminder to complete the DS the Friday following the discharge. For example, for a client discharging on
12/9, the therapist was sent a calendar invite with a reminder on 12/11 to complete the DS.
b. In-service training for therapists (including MTPs [Master Treatment Plans], DSx [diagnoses] and use of least restrictive interventions) is scheduled for 12/7 and signatures will be obtained as confirmation of training.
c. Incident reports: i. Incident reports will be reviewed once a week for completeness and accuracy by the Operations Director or qualified designee. Operations Director or qualified designee will audit for dates, names, signatures, significant gaps in reporting, and the person completing, beginning 12/3/2020. Incident report review by governing body for trends on 12/3/2020.
ii. In-service training on properly completing an Incident Report (including such topics as: who filled out IR, signatures, gaps in report, dates, etc.) is scheduled for December 15, 2020. Residential Director will administer a test based on the in-service training. Those who do not display proficiency will be re-educated and retrained by the Residential Director or qualified designee.
2. 10A NCAC 27G.0205(c) Assessment and Treatment/Habilitation or Service Plan (v112): Beginning 12/7/20 and ongoing, regular audits for master treatment plans to immediately include client specific goals and strategies, as well as signatures, completed by the Clinical Director or

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V 513	Continued From page 106 qualified designee. a. Electronic Master Treatment Plans (MTPs) are being edited to include a checkbox for families and residents to indicate that they participated in the creation of the MTP. Family Connect will be implemented on our EMR (Electronic Master Record) starting 12/7 through which the signatures on MTPs will be facilitated after seeking input from parent/guardian and client. b. In-service training for therapists is scheduled for 12/7. Training will include: i. Appropriate completion of MTPs including receiving family signatures and protocol for adding new strategies and interventions to the master treatment plan for support changes. ii. Discharge summaries and timely completion. iii. Appropriate use of least restrictive interventions. 3. 122C-62 Additional Rights in 24-hour facilities (v364): Solstice East understands that it is a client right to "communicate and consult with his/her parents or guardian" and "make and receive telephone calls." Residents stated in interviews that during early weeks in the program, they were not allowed to communicate with their families. Residents should communicate weekly with their families--even in the first few weeks following admission--during family therapy. Clinical Director or qualified designee will train therapists on 12/7--reminding them that clients should be involved in family therapy sessions beginning within the first 7 days of their admission, which will fulfill their right to "communicate and consult with his/her parents or guardian" and "make and receive telephone calls." This expectation has been added in the clinical manual. 4. Restrictive Interventions: Solstice East has revised the policies for Therapeutic Holds and Isolation Time-Out to align with State Rules, to include changes in usage of time limits and	V 513		

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V 513	Continued From page 107 authorization requirements. In-service training for therapists (12/7) and direct care staff (12/15) will review use of least restrictive alternatives. a. 10A NCAC 27E.0104(e)(9) Seclusion, Physical Restraint and Isolation Time-out and Protective Devices used for Behavioral Control (v521): In-service training with on-call support staff completed 12/1/20 on the role of student debriefing after a restrictive intervention and follow through. b. 10A NCAC 27E.0104(e)(10) Seclusion, Physical Restraint and Isolation Time-out and Protective Devices used for Behavioral Control (v522): In-service training with on-call support staff completed 12/1/20 on the policy update requiring continued authorizations of restrictive interventions lasting longer than 15 minutes. c. 10A NCAC 27E.0104(e)(16)(B) Seclusion, Physical Restraint and Isolation Time-out and Protective Devices used for Behavioral Control (v524): In-service with on-call support staff completed 12/1/20 to complete documentation of parent notification on Incident Reports when parent notification is necessary. 5. 10A NCAC 27F.0102 Living Environment (v539): Beginning 12/3/20, residents shall be provided an atmosphere for conducive, uninterrupted sleep during sleep hours. The treatment team (including residents responsible professional and qualified professional) may, under circumstances defined below, determine that it is temporarily inappropriate for a resident to maintain the above rights. In this situation, a resident may be required to sleep in a common space, which will be documented in the Crisis Intervention Note found in the resident's clinical file. An eye mask and/or earplugs will be made available to this resident that they may choose to use if light or sound is causing interruption to their sleep. The circumstances under which treatment	V 513		

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V 513	Continued From page 108 team may deem it temporarily inappropriate for a resident to maintain the above rights are high risk of: a. Self-harm. b. Harm to others. c. Sexual acting out. Let it be noted that no residents are currently under this level of precautions as of 2:00pm on 12/3/2020." Describe your plans to make sure the above happens (Each number correlates to the above number.) "1. 27G.0201: Operations director or qualified designee will audit the described tasks on a weekly basis for completion. 2. 27G.0205: Executive Director or qualified designee will review completion of audit conducted by Clinical Director or designee. 3. 122C-62: Executive Director or qualified designee will review that training has taken place in clinical inservice on 12/7. 4. Restrictive Interventions: Policies and procedures for restrictive interventions and in-service training have been revised as stated above as of 12/1/20 and verified by the Executive Director. Additional in-services on 12/7 and 12/15 will be verified for completion by the Executive Director or qualified designee. 5. 27F.0102U: Eye masks and ear plugs were acquired and available for use as of 12/2/20. Use of these precautions will be reviewed by the Clinical Director or qualified designee weekly in the Clinical Meeting." Review on 12/7/20 of a 3rd and an amended Plan of Protection dated 12/4/20 and signed by the Executive Director revealed: -this amended plan was completed by the facility's Founder, Executive Director, Operations Director, Clinical Director, and Assistant Clinical Director. What immediate action will the facility take to	V 513		

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V 513	Continued From page 109 ensure the safety of the consumers in your care? "1. 10A NCAC 27E.0101 Least Restrictive Alternative (v513): Beginning 12/4/20 and ongoing until substantial compliance is achieved and maintained as determined by the governing body, restrictive or non-traditional interventions will be audited on a weekly basis by the Clinical Director or qualified designee. The audit will verify that: a. The least restrictive alternative is being implemented to successfully enable resident(s) to make progress on the challenges and goals present in their treatment b. Interventions are approved by Treatment Team c. Interventions are accurately documented in the resident file or treatment team notes. d. If the intervention will last longer than a traditional intervention, it will be included in the resident's treatment plan. 2. 10A NCAC 27G.0201 Governing Body Policies (v105): The following will occur for the next 30 days and ongoing until substantial compliance is achieved and maintained as determined by the governing body: a. Discharge summary (DS) audits will be done weekly (starting 12/2) by the Clinical Director or qualified designee. In addition, on 12/3/2020, the Clinical Director sent a calendar invite to the primary therapist for each client with confirmed discharge dates in December as a reminder to complete the DS the Friday following the discharge. For example, for a client discharging on 12/9, the therapist was sent a calendar invite with a reminder on 12/11 to complete the DS. b. In-service training for therapists (including MTPs, DSx and use of least restrictive interventions) is scheduled for 12/7 and signatures will be obtained as confirmation of training. c. Incident reports: i. Incident reports will be	V 513		

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V 513	Continued From page 110 reviewed once a week for completeness and accuracy by the Operations Director or qualified designee. Operations Director or qualified designee will audit for dates, names, signatures, significant gaps in reporting, and the person completing, beginning 12/3/2020. Incident report review by governing body for trends on 12/3/2020. ii. In-service training on properly completing an Incident Report (including such topics as: who filled out IR, signatures, gaps in report, dates, etc.) is scheduled for December 15,2020. Residential Director will administer a test based on the in-service training. Those who do not display proficiency will be re-educated and retrained by the Residential Director or qualified designee. 3. 10A NCAC 27G.0205(c) Assessment and Treatment/Habilitation or Service Plan (v112): Beginning 12/7/20 and ongoing, regular audits for master treatment plans to immediately include client specific goals and strategies, as well as signatures, completed by the Clinical Director or qualified designee. a. Electronic Master Treatment Plans (MTPs) are being edited to include a checkbox for families and residents to indicate that they participated in the creation of the MTP. Family Connect will be implemented on our EMR starting 12/7 through which the signatures on MTPs will be facilitated after seeking input from parent/guardian and client. b. In-service training for therapists is scheduled for 12/7. Training will include: i. Appropriate completion of MTPs including receiving family signatures and protocol for adding new strategies and interventions to the master treatment plan for support changes. ii. Discharge summaries and timely completion. iii. Appropriate use of least restrictive	V 513		

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V 513	Continued From page 111 interventions. 4. 122C-62 Additional Rights in 24-hour facilities (v364): Solstice East understands that it is a client right to "communicate and consult with his/her parents or guardian" and 'make and receive telephone calls.' Residents stated in interviews that during early weeks in the program, they were not allowed to communicate with their families. Residents should communicate weekly with their families--even in the first few weeks following admission--during family therapy. Clinical Director or qualified designee will train therapists on 12/7--reminding them that clients should be involved in family therapy sessions beginning within the first 7 days of their admission, which will fulfill their right to 'communicate and consult with his/her parents or guardian' and 'make and receive telephone calls.' This expectation has been added in the clinical manual. 5. Restrictive Interventions: Solstice East has revised the policies for Therapeutic Holds and Isolation Time-Out to align with State Rules, to include changes in usage of time limits and authorization requirements. In-service training for therapists (12/7) and direct care staff (12/15) will review use of least restrictive alternatives. a. 10A NCAC 27E.0104(e)(9) Seclusion, Physical Restraint and Isolation Time-out and Protective Devices used for Behavioral Control (v521): In-service training with on-call support staff completed 12/1/20 on the role of student debriefing after a restrictive intervention and follow through. b. 10A NCAC 27E.0104(e)(10) Seclusion, Physical Restraint and Isolation Time-out and Protective Devices used for Behavioral Control (v522): In-service training with on-call support staff completed 12/1/20 on the policy update requiring continued authorizations of restrictive	V 513		

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V 513	Continued From page 112 interventions lasting longer than 15 minutes. c. 10A NCAC 27E.0104(e)(16)(B) Seclusion, Physical Restraint and Isolation Time-out and Protective Devices used for Behavioral Control (v524): In-service with on-call support staff completed 12/1/20 to complete documentation of parent notification on Incident Reports when parent notification is necessary. 6. 10A NCAC 27F.0102 Living Environment (v539): Beginning 12/3/20, residents shall be provided an atmosphere for conducive, uninterrupted sleep during sleep hours. The treatment team (including resident's responsible professional and qualified professional) may, under circumstances defined below, determine that it is temporarily inappropriate for a resident to maintain the above rights. In this situation, a resident may be required to sleep in a common space, which will be documented in the Crisis Intervention Note found in the resident's clinical file. An eye mask and/or earplugs will be made available to this resident that they may choose to use if light or sound is causing interruption to their sleep. The circumstances under which treatment team may deem it temporarily inappropriate for a resident to maintain the above rights are high risk of: a. Self-harm. b. Harm to others. c. Sexual acting out. Let it be noted that no residents are currently under this level of precautions as of 2:00pm on 12/3/2020." Describe your plans to make sure the above happens (Each number correlates to the above number.) "1. 10A NCAC 27E.0101: Executive Director or qualified designee will review audit conducted by the Clinical Director or qualified designee on a weekly basis. 2. 27G.0201: Operations director or qualified designee will audit the described tasks on a	V 513		

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V 513	Continued From page 113	V 513		

weekly basis for completion.
3. 27G.0205: Executive Director or qualified designee will review weekly completion of audit conducted by Clinical Director or designee.
4. 122C-62: Executive Director or qualified designee will review that training has taken place in clinical inservice on 12/7.
5. Restrictive Interventions: Policies and procedures for restrictive interventions and in-service training
have been revised as stated above as of 12/1/20 and verified by the Executive Director. Additional in-services on 12/7 and 12/15 will be verified for completion by the Executive Director or qualified designee.
6. 27F.0102U: Eye masks and ear plugs were acquired and available for use as of 12/2/20. Use of these precautions will be reviewed by the Clinical Director or qualified designee weekly in the Clinical Meeting."

Solstice East is a residential facility for adolescent females ages 15-18 whose diagnoses included Major Depressive Disorder, Attention-Deficit Hyperactivity Disorder, Generalized Anxiety Disorder, Post-Traumatic Stress Disorder, Oppositional Defiant Disorder, other specified Trauma and Stressor Related Disorder and Parent Child Relational Problems. Histories include self-harm, suicidal ideation, anger management, physical and verbal aggression and violence toward peers/family and substance abuse.

Safety Phase was used as a behavioral consequence which included increased assignments, communication restrictions, required clients to stay within arms length of staff, sleeping in the common area, and isolation time-out. Safety was utilized as a first response to

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V 513	Continued From page 114 a behavior instead of the use of less restrictive alternatives. Safety as a consequence also include clients being required to participate in team interventions with peers. These interventions were utilized for all peers in the group, and were not individualized to the needs of the clients. For one client, this intervention caused overwhelming emotions leading to threats of self-harm. This resulted in the client requiring an emergency medical evaluation at a local hospital. There were 5 incidents of failure to implement their discharge planning policy for each client's summary of their successes and failures, treatment services or continued needs following discharge. There were at least 21 documented restrictive interventions utilized between 3/28/20-10/23/20 for at least 10 clients. However, the total amount of restrictive interventions were unable to be determined, as medical records for sampled clients reflected a routine use of safety phase. Safety phase was not identified as restrictive intervention by facility and therefore not included in incident reports. The facility's lack of compliance with their own policy of reviewing trends and patterns of incidents resulted in hindering their ability to address continuing problematic behaviors. Treatment plans, restrictive interventions and programming did not take into consideration individualized needs of each client. FC #15 was diagnosed with Autism Spectrum Disorder among other diagnoses and was held in restrictive interventions 6 different occasions for at up to at least 4 hours on one event. Additionally, Client #5 had 5 restrictive interventions, one of which lasted at least 5 hours. Due to the lack of	V 513		

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V 513	Continued From page 115	V 513		

consistent documentation it is unknown when, how often and for how long clients were on restrictive interventions. Treatment plans were not updated to reflect individualized needs and the use of restrictive interventions, including the use of Safety. Additionally, treatment plans were not updated to reflect goals and strategies to address clients who had behaviors including AWOL (absent without leave), self-harm, and medication refusals.

According to the facility's programmatic phase system, clients were not allowed to make phone calls to their guardians during the first 2 phases which lasted anywhere from 2 weeks to 2 months. All client, guardian and staff interviews were consistent with this policy.
There were 6 clients and 11 incidents of no client debriefing after a restrictive intervention. There were 5 clients who were held or in restrictive intervention for more than 15 mins to 5 hours without authorization. Two incidents did not identify staff who were involved in holding, performing what hold or for how long. There were 4 clients and 9 incidents of no immediate notification to guardians or notification that longer than the following day.

For 5 clients, which included at least 6 restrictive interventions, there was no documentation of an authorization for the restrictive intervention to continue beyond 15 minutes. There was also no documentation that an assessment of physical and mental well-being was conducted by a Qualified Professional after these restrictive interventions. For 6 clients, which included 11 restrictive interventions, there was no evidence that a debriefing occurred after the restrictive interventions. For 4 clients, including 9 incidents, there was no immediate notification of the

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V 513	Continued From page 116 guardian. As part of the safety phase, clients were routinely required to sleep on their mattress in the common area. This resulted in clients reporting their lack of ability to sleep due to staff walking in and out of the area and the lighting in the area. The lack of individualized services, treatment strategies, alternatives to restrictive interventions to address client presenting and evolving behaviors resulted in persistent safety issues. The lack of following programmatic policies, tracking incident reporting trends coupled, with the lack of individualized services created serious neglect. This deficiency resulted in a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $3000.00 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 513		
V 521	27E .0104(e9) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (9) Whenever a restrictive intervention is utilized, documentation shall be made in the client record to include, at a minimum: (A) notation of the client's physical and psychological well-being; (B) notation of the frequency, intensity and duration of the behavior which led to the	V 521	V521: Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control: Facility failed to ensure each client's restrictive intervention was appropriately documented and followed by a debriefing of each client RI Solstice East's Governing Body reviewed Tag V521 and gave direction for the following corrections, preventative measures and ongoing monitoring to take place: Correction: In-service trainings addressed deficiencies in documentation and debriefing of clients following a restrictive intervention: 1. Residential on-call staff on 12/1/20 2. Residential direct care staff on 12/15/20 3. Clinical staff on 12/4/20 and 12/7/20	

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V 521	Continued From page 117 intervention, and any precipitating circumstance contributing to the onset of the behavior; (C) the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used; (D) a description of the intervention and the date, time and duration of its use; (E) a description of accompanying positive methods of intervention; (F) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions; (G) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and (H) signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure each client's restrictive intervention (RI) was appropriately documented and followed by a debriefing of each client RI incident for 4 of 11 current audited clients (Client #3, Client #4, Client #5 and Client #9) and for 2 of 7 former audited clients (FC #15, FC #18). The findings are: Refer to tags V112, V513, and V522 for additional information.	V 521	Continued From page 117 Implemented Restrictive Intervention Report to be completed by on-call supervisor or designee when RI is utilized, which includes: 1. Status of the physical and psychological well-being of client 2. Description of behaviors (frequency, intensity, and duration) leading up to RI 3. Rationale for the use of RI 4. Documentation of the date/time and duration of RI 5. Description of accompanying positive methods of intervention 6. Description of debriefing with client and staff 7. Identification of staff conducting RI and completing documentation Prevention and Monitoring Measures: Weekly audits to monitor and prevent deficiencies in documentation of Restrictive Interventions and debriefing clients following Restrictive Interventions, which include: 1. Incident reports (including use of RI) by Program Director or qualified designee 2. Restrictive or non-traditional interventions by Clinical Director or qualified designee to verify that interventions were accurately documented in the resident file or treatment team notes 3. Shift notes by Program Director or qualified designee If deficiencies are noted in the above audits, the following action plans will be implemented until substantial compliance is achieved as determined by the Governing Body: 1. Performance evaluations of staff 2. Identified and continued training of staff 3. Documentation of in-services provided or plan for improvement The Governing Body will review restrictive interventions and trends quarterly (or as needed, defined by the governing body) and create an action plan specific to each trend. Department managers will carry out the plan of correction quarterly (or as needed, defined by the governing body). Auditing will continue per above plans until substantial compliance is met and maintained as directed by the Governing Body.	

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V 521	Continued From page 118 Review on 10/9/20 incident reports for Client #3 revealed: -there was no debriefing report for her written incident report dated 9/8/20. Record review on 10/15/20 for Client #4 revealed: -there were no debriefing reports for her written incident reports dated 6/7/20 and 7/29/20; -her 8/25/20 debriefing report of her 7/30/20 and 7/31/20 incident did not clarify whether Client #4 was voluntarily in the basement or if she was placed in this location by staff as a RI, if she had been on safety monitoring by staff prior to being moved to the basement (as increased safety measure), and there were no descriptions provided of her physical restraints (what staff used the holds, the time(s) of each hold and how many holds were used with Client #4). Review on 10/12/20 of written incident reports for Client #5 revealed: -there was an undated, written debriefing report of her 4/11/20 "attempted" elopement from the facility with no named staff or positions that identified who conducted the debriefing or completed the report; -this report did not include the total duration of her RI, the duration of each RI, the effect(s) on Client #5 with each RI, and description of positive methods of intervention used with her; -there were two undated, written debriefing reports of 2 incidents on 4/14/20- one incident at 2:13 pm and involved her jumping into a pond and her attempted elopement while outdoors and the 2nd incident began at 7:11 pm with her attempted elopement from inside the facility; -statements included in the 2nd debriefing report indicated that after her RI hold was loosened "after about an hour," Client #5 became " ...non-communicative and stared at a spot on the	V 521		

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V 521	Continued From page 119 floor. Eventually she got in her sleeping bag;" -there were no named staff or position to identify who completed the reports; -there was no debriefing report for her written incident report dated 8/10/20; -the debriefing report for her reoccurrence of an attempted elopement on 8/25/20 was undated, had no name or position to identify who completed the report, and in the investigate alternatives section, there was a question about assessing clients who were on restrictions during crisis moments. Record review on 10/15/20 for Client #9 revealed: - there was no debriefing report for her written incident report dated 4/25/20. Review on 9/30/20 of incident reports for FC #15 revealed: -No documentation of debriefing with FC #15 for incidents on 6/25/20, 8/9/20 nor 8/26/20. -No documentation of duration of each hold on 6/25/20 or the "off and on" holds on 8/26/20. Review on 10/12/20 of incident report for FC #18 dated 9/14/20 at 9:33pm revealed: -No documentation of debriefing with FC #18 for this incident. This deficiency is cross referenced into 10A NCAC 27E .0101 Least Restrictive Alternative (V513) for a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 521		
V 522	27E .0104(e10) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED	V 522	V522: Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control: Facility failed to ensure each client with a restrictive intervention of more than 15 minutes had verbal and written authorization, as well as, a physical and mental well-being assessment by a qualified professional that extended the restrictive intervention.	

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V 522	Continued From page 120 FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (10) The emergency use of restrictive interventions shall be limited, as follows: (A) a facility employee approved to administer emergency interventions may employ such procedures for up to 15 minutes without further authorization; (B) the continued use of such interventions shall be authorized only by the responsible professional or another qualified professional who is approved to use and to authorize the use of the restrictive intervention based on experience and training; (C) the responsible professional shall meet with and conduct an assessment that includes the physical and psychological well-being of the client and write a continuation authorization as soon as possible after the time of initial employment of the intervention. If the responsible professional or a qualified professional is not immediately available to conduct an assessment of the client, but concurs that the intervention is justified after discussion with the facility employee, continuation of the intervention may be verbally authorized until an on-site assessment of the client can be made; (D) a verbal authorization shall not exceed three hours after the time of initial employment of the intervention; and (E) each written order for seclusion, physical restraint or isolation time-out is limited to four hours for adult clients; two hours for children and adolescent clients ages nine to 17; or one hour for clients under the age of nine. The original order shall only be renewed in accordance with these limits or up to a total of 24 hours.	V 522	Continued From page 120 Solstice East's Governing Body reviewed Tag V522 and gave direction for the following corrections, preventative measures and ongoing monitoring to take place: Correction: The Governing Body has reviewed and edited program policies and procedures for restrictive interventions to include the continued assessment and authorization of a restrictive intervention exceeding 15 minutes by a Qualified Professional. In-service trainings addressed areas of deficiencies in authorization of restrictive interventions exceeding 15 minutes: 1. Residential on-call staff on 12/1/20 2. Clinical staff on 12/7/20 3. Residential direct care staff on 12/15/20 Implemented Restrictive Intervention Report to be completed by on-call supervisor or qualified designee when RI is utilized, which includes documentation of: 1. Qualified Professional providing continued authorization for use of restrictive intervention 2. Assessment of physical and mental well-being of client Prevention and Monitoring: Weekly audits to monitor and prevent future deficiencies in authorization of restrictive interventions exceeding 15 minutes by a Qualified Professional, including: 1. Incident reports (including use of RI) by Program Director or qualified designee 2. Restrictive or non-traditional interventions by Clinical Director or qualified designee to verify inclusion in the client's MTP if the intervention lasted longer than a traditional intervention 3. Shift notes by Program Director or qualified designee If deficiencies are noted in the above audits, the folColowing action plans will be implemented until substantial compliance is achieved as determined by the Governing Body:	

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V 522	Continued From page 121 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure each client with a restrictive intervention (RI) of more than 15 minutes had verbal and written authorization, as well as, a physical and mental well-being assessment by a qualified professional that extended the RI for 4 of 11 current audited clients (Client #3, Client #4, Client #5 and Client #9) and for 3 of 7 former audited clients (FC #15, FC #16, FC #18). The findings are: Refer to tags 112, 513, 521, 524 for additional information. Review on 10/9/20 of Therapeutic Holding Policy updated May 2019 revealed: -"A 'brief hold' is any approved, time limited restraint lasting less than 30 minutes. Brief holds include only physical restraint for the student's safety and are always body to body. The only time brief holds are permitted for use is when a resident's behavior presents: 1-A danger to self, 2-A danger to others, 3-destruction of property ... -Brief hold policies and procedures: 1-Brief holds should only be used as last resort; 2-Brief holds should only be used to assessed risk to self or others and not as behavioral punishments or behavioral management tools; 3-Before using a brief hold, the clear criteria contained in these procedures must be met; 4-Only employees who have been trained in current Solstice East procedures concerning brief holds may carry out the procedures; 5- whenever a brief hold is implemented, the primary therapist or Clinical Director must call and inform parents; 6- Nursing should be notified as needed if	V 522	Continued From page 121 1. Performance evaluations of staff 2. Identified and continued training of staff 3. Documentation of in-services provided or plan for improvement The Governing Body will review restrictive interventions and trends quarterly (or as needed, defined by the governing body) and create an action plan specific to each trend. Department managers will carry out the plan of correction quarterly (or as needed, defined by the governing body). Auditing will continue per above plans until substantial compliance is met and maintained as directed by the Governing Body.	

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V 522	Continued From page 122 possible injuries have occurred; 7-After a brief hold has been used, the appropriate staff involved should hold a debriefing with the resident involved; 8- When brief holds are enacted, careful measure should be taken to protect the rights, dignity and wellbeing of the student. If the student needs to be separated from other students, employees should use nurturing language, inform the student of all actions, pay respectful attention to clothing and body parts and never deprive the student of physical essentials; 9-Staff should be trained in early detection of potential risks during brief hold procedures; 10-An incident report must be filled out for each brief hold and employees who participated in each should engage in a 'debriefing' with their immediate supervisor ..." Review on 10/6/20 and 12/7/20 of Staff #1-#30 personnel records revealed staff were currently trained in CPI (Crisis Prevention Institute) as the facility's curriculum for de-escalation and restrictive interventions. Review on 10/9/20 incident reports for Client #3 revealed: -Incident Report (IR) dated 9/8/20- she told Staff #5 she had urges to run away from the facility and did not want to be placed in a hold (restrictive intervention); -she was kept in staff eyesight while she walked back to the facility and did not have a physical restrictive intervention used on her by a staff; -"[Client #3] was placed on safety and restricted to the [facility];" -a lack of documentation made it difficult to determine the type of Client #3's restriction to the facility, her anticipated length of time in this restriction, whether the restriction was a planned	V 522		

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intervention, and specifics about her additional safety measures.

Review on 10/15/20 of 3 written incident reports for Client #4 revealed:
-on 6/7/20, she was observed by Staff #11 and Staff #12 going into her room for "less than a minute" after a stressful experience with her peers. When she came out of her room, she told the two staff she drank 4 large gulps of shampoo;
-a recommendation was made she be taken to a local hospital in the event she had ingested something else in addition to shampoo after Staff #12 notified a medical nurse on-call and a poison control agency.
-There was no documentation that indicated a local hospital visit. Her vital signs were checked twice by Staff #12 and noted to be normal. She was placed on safety precautions that included arms-length staff supervision, door cracked and counting in bathroom, soaps removed from the bathroom, and her sleeping arrangement was restricted to the common area.
-on 7/29/20, she attempted to self-harm while on a safety precaution (she was placed on-arms staff supervision) with Staff #11;
-she told Staff #11 she was going to brush her teeth. During this process, she picked up an alcohol-free, non-toxic mouthwash from the bathroom counter and drank "multiple swigs" of this substance;
-she refused to cooperate with Staff #11's direction to drink water;
-the team manager and a poison control agency were notified by Staff #11 but no specific information or instructions were documented as a result of these notifications;
-she refused to answer questions to a suicide risk assessment.
-on 7/30/20, she walked up from the basement of

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the facility to her bedroom at 11:43 pm, barricaded herself in her bathroom, threatened to drink shampoo, was placed in a "team wrist" hold that lasted 5 minutes with a begin time of 4:00 and an end time of 4:05;

-the staff identified to have been present during this incident included Staff #18, Staff #19, and Staff #22 but there was a lack of documentation which made it difficult to determine which staff initiated or if all staff participated in her RI.

-Review on 10/20/20 of two printed emails from a team manager (Staff #27) dated 7/31/20 at 1:06 AM and 8/2/20 at 5:56 PM and sent to the team staff and facility lead staff revealed:

-7/31/20, Client #4 was moved away from her peer team and into the basement of the facility due to her escalated behaviors that included banging her head against the bathroom wall and door, and continued refusal to eat a meal;

-She required 2 staff present in her room with increased safety precautions implemented (arms supervision, door cracked and client counting when she was in bathroom, removal of all items in bathroom and an expectation she was to communicate with a staff before she moved off the couch or she would be placed into a restrictive intervention for safety).

-"She was in and out of holds for attempting to bang her head against the wall and floor."

-a written psychiatrist note dated 8/13/20 revealed that Client #4 had decreased her eating and drinking water to the extent her blood pressure dropped to 74 over 49 (74/49) which led to being admitted to a local hospital from 8/2/20 to 8/10/20.

Review on 10/12/20 of 4 of 6 written incident reports for Client #5 revealed: -her 1st incident on 4/11/20 of attempted elopement from the facility led to an RI, which " ...changed over time based

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on her cooperation but lasted about 5 hours total."
-she was outdoors with the recreational staff and she took off running with an intent to elope;
-the statement about Staff #3 having "grabbed her arm" and held her until Staff #4 arrived and assisted with her RI was stated in this incident report.
-her 2nd incident (1 of 2 reports on 4/14/20) at 2:13 pm involved her jumping into the pond on her way to school and she then tried to run away. She was verbally unresponsive but was observed by Staff #4 treading water. After Staff #3 helped her out of the water, she attempted to run and was placed in "a couple of holds" by Staff #3 and Staff #4. She was taken to a room in the facility by these staff;
-the report indicated there were additional, unnamed staff who were present and surrounded the pond when Client #5 exited the water. She ran from staff which led to her RI and her RI lasted 1 hour.
-the 3rd incident (2 of 2 incidents on 4/14/20) at 7:11 pm occurred when she tried to elope from a room inside the facility where she was transported to earlier in the day. Her exit from the door was blocked by Staff #19 and Staff #29's bodies pushed against the door and she received a verbal warning about an RI if she did not move back into the room. She was restricted to this room in the facility for almost 4 hours.
-her refusal to move from the door led to her RI by these 2 staff. Client #5 fought with these staff and kicked the wall. Her RI lasted "about an hour" before she eventually went to sleep in her sleeping bag.
-on 5/3/20, Client #5's occurrence of an attempted elopement led to her RIs, which were identified as used with her for a period of "3 hours or more" and with a "variety of transport holds;"

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V 522	Continued From page 126 -she was outdoors and began pacing when she ran further through a back pasture, up a neighbor's driveway, and continued through the woods that paralleled the road while a team of staff (Staff #12, Staff #20, Staff #21, and the Program Director who arrived later to provide team support) followed her and local law enforcement was notified for assistance to return her to the facility; -she and staff had injuries which were combined in this report and included cuts, bruises, and muscle pulls. Based on a lack of documentation, it could not be determined what injuries she sustained from this incident. -on 8/10/20 was her 5th incident of attempted elopement since her admission on 4/9/20; She was placed in an RI for 45 minutes by Staff #19 when she attempted to exit the room and run. The RI was released when client's breathing slowed and she communicated with this staff. -her 6th elopement attempt escalated on 8/25/20 when she walked off from her assigned location at school without anyone having noticed and made her way onto the roof of one of the facility buildings where Counselor #1 and Counselor #3 attempted to talk her down from the roof; -When local first responders (fire department and law enforcement) arrived to assist with this situation, Client #5 jumped to the lower part of the roof and was caught by Counselor #1 before she rolled completely off the roof. She was placed on the ground, restrained by local law enforcement and transported to a local hospital where she was treated for a left sprained ankle. -although her primary therapist was notified about her behaviors, there was no documentation that indicated staff verbally, or in writing, received authorized for the RIs and received continued authorization for her RIs beyond the 15-minute restraints in each incident;	V 522		

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V 522	Continued From page 127 -there was no documentation that her therapist or a member of the clinical staff met and conducted an assessment of Client #5's physical and psychological well-being soon after the RI was employed by a staff with her in each incident. -the reports did not include how many RIs were used with Client #5, what staff were involved and what staff initiated the RI with her, and what type(s) of support were provided when additional staff arrived onsite during her RI incident, and what plans were made for follow up to prevent reoccurrences of the incidences that led to a RI; -she had at least 4 separate physical restrictive intervention incidents that involved a restraint beyond 15 minutes without additional authorization; Review on 10/15/20 of a written incident report for Client #9 revealed: -the report was dated 4/25/20 at 4:12 pm; -she started out her morning with a refusal to get out of bed and she told Staff #8 and Staff #12 she was feeling unsafe and was looking for an opportunity to run; -Staff #8 and Staff #12 determined she needed to be moved to a safer location. She was placed in a transport hold that lasted about 5 minutes and transported to a group room; She was restricted in this room with staff documentation did not reflect the duration of the restriction. -a statement in the report indicated that she did not run but attempted to run. -While restricted to the room she completed assignments and ate a meal; -one sentence that Staff #8 and Staff #12 debriefed about the incident but no additional information was provided about the RI, who authorized the RI, and possible alternatives to future RI use that included isolation time-out.	V 522		

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V 522	Continued From page 128 -Review on 9/30/20 of incident reports for FC #15 revealed: -6/25/20- unknown time -unknown length of time "Client walked out of her room, down the stairs and out the door. Staff followed and asked what was going on and what her plan was. Client told staff she didn't care about herself and said that staff could not put their hands on her. Staff set a boundary and told her that if she got to the road, they would go hands on. Client said she would punch them. Client began to run. Her shoes came off while she was running. She ran through the field and into the woods where staff followed her through the thorns and across the creek. Staff explained choices of cooperating or needing to go hands on. Client was combative in speech and turned around and followed staff across the creek but then started running down the creek and up the bank. At the top of bank Client began shoving staff and was put in a team hold. Client struggled and fought a lot. Client kicked, pinched, scratched, slapped, bit and punched staff throughout the restraint. When staff tried to transport her, she fought and kept trying to run. Staff decided to hold client in transport while two other staff lifted her legs to carry her. Staff carried her to the van and put her in it. Staff transported her this way from the van to a room in the building." -6/27/20 315pm- "team hold-2 hours" "[FC #15] walked downstairs and paced around the common area. [FC #15] walked outside. Staff followed and held the boundary. [FC #15] got in a chair and refused to get out. Staff informed her that being outside is not safe, asked her to walk herself to the group room or they would have to transport her. [FC #15] replied that she is not harming herself and staff can't make her. Staff replied that she is not safe outside and	V 522		

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they will transport her if she refuses to go in. [FC #15] refused for quite a while. Staff eventually picked her up and carried her into the group room. [FC #15] fought, hit, kicked, bit slammed her head. Staff kept her safe and she was not able to hurt herself or others. After calming down, staff went hands off. [FC #15] got up and started slamming her head in the wall. Staff interceded and held her until she calmed down again. [FC #15] got in bed. She immediately wrapped her sheet around her head. Staff were able to get it off and remove it from her. She was told to leave her head visible or she would lose the rest of her bedding and be down to mattress only. [FC #15] kept her head out. She refused meds throughout this. She asked for a PBJ. [Staff #9] negotiated that she would take her med in return for a sandwich. [FC #15] took her med, ate her sandwich and finally went to sleep."

-8/9/20 at 630pm- "team hold hour and a half-wrist hold and light transport"

"Client came out of the bathroom after being in there for about 7 mins and sat on the kitchen floor in a corner. Client ignored staff and was unresponsive with the exception of telling staff to get away from her. Client began to bang her head on the wall. Staff asked client to stop, client ignored. Staff told client if she was not going to keep herself safe, staff would have to go hands on to help her stay safe. Staff went hands on with client to prevent her from banging her head on the wall. Staff held on to wrists and put their hands on the wall to prevent further head banging. Client kicked and punched staff. At one point keys got caught around staff's neck and client yanked on it with her foot while making eye contact with staff. Client attempted to bite staff multiple times and scratched staff's hands. Client was in hold for about an hour and a half fighting staff. Client was uncommunicative throughout

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this but was able to walk down with staff to the basement. Client eventually was let out of her holds as she became regulated."

-8/10/20 at 0701 "team hold -4 hours"

"Around 8:45 [FC #15] began tapping her head on the wall. [Staff #14] commented on this asking if she needed anything. The tapping intensified over the next ten minutes turning into intense banging and [FC #15] moved a pillow to block [Staff #14] from seeing her arms and face. [Staff #14] asked [FC #15] to remove the pillow and to stop hitting her head on the wall. At this point [Staff #14] radioed to have second mentor come support. [Staff #15] was able to support and they both worked together to get the pillow out of [FC #15]'s hands which took over ten minutes due to her kicking both [Staff #14] and [Staff #15]. [Staff #14] named that it would be difficult to keep her safe on the top bunk because of her kicking them. [FC #15] became more escalated by them removing the pillow and began grabbing other sheets, blankets, shirts in the area to wrap around her head and neck. This escalated to her trying to strangle herself with the items. [Staff #15] radioed for support and [Staff #14] and [Staff #15] got into the bunk with [FC #15]. [Staff #21] showed up for support while [Staff #15] was holding [FC #15]'s hands and keeping her from hitting her head on the wall and [Staff #14] was holding down [FC #15]'s legs as she kicked and shoved her. [Staff #21] was able to support her legs. [FC #15] fought them off and on but was able to regulate and communicate with them. She agreed to keep herself safe and expressed needing to use the restroom. Mentors were clear that they needed a commitment from her to be safe before that could happen. After a few minutes of deep breaths [FC #15] made her way to the restroom. On her way back from the restroom she grabbed a shirt and ran up the

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ladder to her bed. She began choking herself with the shirt so [Staff #14], [Staff #15] and [Staff #21] all intervened. [Staff #21] had [FC #15]'s arms and [Staff #15] kept her from kicking with her legs. [Staff #14] offered support by removing items from the bunk and helping hold her limbs when she would squirm. [FC #15] was in a hold with [Staff #21] and [Staff #15] until 10:30. Mentors offered multiple times when [FC #15] was calmer to move off of the top bunk. A few times [FC #15] complied but then tried to jump off the bunk. She yelled "I want to die" and unable to commit to being safe for some time. At 10:30 [Staff #22] switched [Staff #21] out. At 10:50 [Staff #24] switched out [Staff #15]. Around 11:45 [FC #15] was able to communicate she would be safe and came down the ladder safely. [Staff #14] and [Staff #23] went into the hold with [Staff #22] and [Staff #24] to ensure [FC #15] got down safely. [Staff #14] and [Staff #23] held onto [FC #15]'s arms as she walked out of her room, but she began fighting once they got to the doorway. [Staff #22], [Staff #24], [Staff #14] and [Staff #23] were able to safely get her to the couch in the common area. [FC #15] fought back every few minutes. At 12:15 [Staff #26] switched [Staff #22] out and [Former Staff #32] was support with [FC #15]'s legs and arms when she would kick and fight. [FC #15] was settling down and day mentors [Staff #14], [Staff #23], [Staff #19], [Staff #25] and [Staff #22] prepared to leave. At this time [FC #15] began fighting harder and was able to get off the couch. [Staff #14], [Staff #25] and [Staff #19] responded as support but [FC #15] was able to slip out of everyone's hold by taking her sweatshirt off. She began running to the emergency exit outside room 11. [Staff #26] was thrown into the wall while running after [FC #15] and [Staff #25] and [Staff #19] both fell on their knees while trying to get ahold of [FC #15]. [Staff

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#25] was able to catch her just before she reached the door. [Staff #25], [Staff #19], [Staff #22], [Staff #23], [Staff #26], [Staff #24] and [Former Staff #32] were able to get her safely back to the couch. [FC #15] fought with [Staff #22] and [Staff #24] on the couch for about an hour. She kicked, bit scratched and clawed. [Staff #25], [Staff #19], [Staff #23] and [Former Staff #32] offered support by securing her legs and arms when she was fighting. Around 1am [FC #15] began to complain about the pressure of the holds on her feet. [Staff #25] let [FC #15] know that she'd love to remove the hold from her feet but she needs to know that she can trust [FC #15]. [Staff #25] asked [FC #15] if her plan was to continue struggling all night or if she like to go to sleep, since she was clearly tired. [FC #15] said that" (no additional information was recorded).
[Staff #6] and [Therapist #3] were contacted and it was decided [FC #15] should be transported to the den. This happened when it was safe enough to transport her down there. [FC #15] was able to walk herself to the den around 1:15am."
-8/26/20 -"team hold- on and off for nearly 2 hrs"
"Around 9pm, [FC #15] got up and ran out of the den, up the stairs and outside through the common area despite staff asking her to stop. Staff was with her outside and another staff joined and they went hands on due to the client not stopping and it was dark outside. Supporting staff arrived and [FC #15] struggled for a few minutes (hitting, kicking, scratching) before settling down. [FC #15] was transported with staff holding either arm (although compliant) back to the den. [FC #15] continued to struggle in and out of holds throughout the remainder of the night (attempting to self harm, hitting staff, struggling, etc.). [FC #15] calmed down and agreed to get in

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bed around 11pm and remained quiet after that."
-no documentation that indicated staff verbally, or in writing, received authorized for the RIs nor received continued authorization for her RIs beyond the 15-minute restraints in each incident;
-there was no documentation that an assessment of FC #15's physical and psychological well-being was conducted after each RI was employed by a staff with her in each incident.

Record review on 9/30/20 of incident reports for FC #16 revealed:
-IR dated 3/28/20 "[Staff #10] walked into the common area to help with a CNC (bathroom door was cracked and student is counting to maintain communication with staff at the door) for another client. [Staff #10] asked [FC #16] if she could transition over to room 4 so she could stay on arms. [FC #16] was finishing up putting up a game. [FC #16] was unable to fit a piece in the box and curled up in a ball on the floor. [FC #16] then started to say, "I can't" over and over. [Staff #10] was talking [FC #16] through it some and then [FC #16] began to say "I want to go home" over and over. The team was in the movie room and [Staff #10] sent [another client] and FC #18 into the movie room so it was just [FC #16] and two staff in the common area with her ([Staff #10] and [Staff #11]). [FC #16] began to breath heavily. [FC #16] then got up quickly and headed for the porch door, opening it and beginning to run towards the stairs. [Staff #10] and [Staff #11] were right behind her, telling they were going hands on and put [FC #16] into a therapeutic hold. [FC #16] was saying "I can't do this. I want to go home. I can't" over and over while in the hold. [Staff #10] and [Staff #11] guided [FC #16] over to the table on the porch. [FC #16] kept saying over and over that she didn't want to sit down. [Staff #12] soon came out on the porch

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and helped guide [FC #16] to sit down. [FC #16] continued breathing heavily. [Staff #11] led [FC #16] in a grounding activity and after about 5 mins [FC #16]'s breathing slowed. [FC #16] sat in the hold for the next 40-45 minutes on the porch. [Staff #10] and [Staff #11] had light conversation with [FC #16] some towards the end. [Staff #10] asked [FC #16] if she was ready to go inside. [FC #16] said she didn't care. [Staff #10] then asked [FC #16] if she had any urges. [FC #16] rated her urges at a 6. [Staff #10] told [FC #16] that she didn't feel safe with her taking a shower unless it was through a CNC. [FC #16] said she didn't want a CNC so she didn't shower. [FC #16] and [Staff #10] walked inside together and got [FC #16]'s things out in the common area and [FC #16] then laid down and began to read."

-review of incident of 4/11/20 -5:10pm-5:15pm transport hold - team restraint 40 mins revealed: "[FC #16] stated she was sad and misses a former peer. [Staff #14] said this is ok, it's ok to feel sad and miss someone you care about. [FC #16] said no its not. A peer stated the impact to her and to [FC #16]'s roommates due to [FC #16] not doing her chore. A peer also told [FC #16] that she was capable of doing her chore. [Staff #14] waited a few minutes and asked [FC #16] to do her chore again. [FC #16] sat and methodically tore up paper for a few minutes from her bed. [Staff #14] asked what was coming up for [FC #16] and [FC #16] did not respond. [Staff #14] said she would not be making more effort than [FC #16] if [FC #16] was unwilling to communicate. [FC #16] got up abruptly, walked to her dresser to drawer and dumped an entire bag filled with tiny pieces of paper torn up and said "Im going to the basement." [Staff #14] attempted to stop [FC #16] verbally and then motioned to [Staff #13] on the way. [Staff #13] and [Staff #14] attempted to block the door to the

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V 522	Continued From page 136 -there was no documentation that an assessment of FC #16's physical and psychological well-being was conducted after each RI was employed by a staff with her in each incident. Review on 10/12/20 of incident reports for FC #18 revealed: -Incident report dated 9/12/20 at 615pm "[FC #18] was pacing and asking to go the doctor. She said she had a brain injury and needed to see a doctor. She said she was in a lot of pain and her head hurt and that everything was horrible. [Staff #8] told her that she could see the nurses on Monday but until then for her to drink water (which she hadn't done all day) and to eat. [FC #18] did not like the answer and said she needed to go to the doctor now. [Staff #8] told her no and that it was not an emergency. [FC #18] cried and continued to plea and say she needed a doctor. Eventually she tried to go outside. [Staff #8] stood in her way but she made her way to a different door. When on the porch [Staff #8] got in front of her and prevented her from leaving the porch. [Staff #7] came to support and talked to [FC #18] too. [FC #18] briefly appeared to calm down but worked herself again by saying she needed a doctor. [FC #18] refused skills and continued to cry and yell about needing a doctor. At this point, staff had been out in the rain with [FC #18] for 30 mins and it was getting darker and raining harder. [FC #18] was given multiple offers and opportunities to walk inside and refused. [Staff #8] initiated hands on to escort [FC #18] inside with the support of [Staff #7] and with [Staff #9] providing extra support if needed. Staff were able to escort [FC #18] to the Eno group room, with her struggling most of the way. The hold was released when she was inside the group room." -9/14/20 at 9:33pm "client [FC #18] ran out of	V 522		

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lodge door, ran around the pond and down the hill until 2 staff blocked her way and she stopped running. Staff used hands on to gently guide client back into the building with her voluntarily walking.
-no documentation that indicated staff verbally, or in writing, received authorized for the RIs nor received continued authorization for her RIs beyond the 15-minute restraints in each incident;
-there was no documentation that an assessment of FC #18's physical and psychological well-being was conducted after each RI was employed by a staff with her in each incident.

Interview on 11/3/20 with a relative of Client #4 revealed:
-The relative stated Client #4's guardian refused to be interviewed;
-The relative received weekly updates on Client #4's treatment progress;
-Client #4 ended up drinking mouthwash and was taken to a local hospital emergency room to make sure she was okay. There was nothing medically wrong with her. She did not want to go an alternative school after her discharge from the facility and hoped if she made things worse, she would be sent home instead.
-She asked Client #4 about whether she was locked up in a room or restrained while at the facility. Client #4 told her she had been taken down by staff into the facility's basement. She was in the basement because she was a safety risk to herself and others. She was not locked up in a room. She was not restrained by staff. There were staff around her whenever her safety was a concern. She had 1 on 1 staff with her when they were concerned for her safety.

Interview on 11/3/20 with Client #5 revealed:
-she did not recall the lengths of the holds in each

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of her RI incidents. Interview on 11/3/20 with Client #5 revealed:
-the first time she ran away, she ran down the street and staff caught up with her and "grabbed" her by the arm and then another staff "grabbed" the other arm;
- they (Staff #3 and Staff #4) put one of their arms through each side of her arm under her elbow and stood with her trying to get her to regulate (calm down). She denied she was unresponsive at any time.
-Another time she was placed in a hold (RI) was outdoors around the pond area and the same staff (Staff #3 and Staff #4) did a team hold (RI) on her. The staff faced outward and she was bent down and leaned forward. She denied she was dragged by staff during her RI.

Interview on 11/3/20 with Client #9 revealed:
-she was physically restrained by staff once or twice for attempts to run away and staff moved her to another place in the facility;
-she was placed in a group room for self-harming behavior instead of a room in the basement because someone was in the basement in quarantine at the time;
-when a client tried to run away, they were placed in the group room and normally 1 staff would sit at the door;
-sometimes there would be a camera put in the room and used to monitor staff's and the client's actions to make sure bad things did not happen.

Attempts on 11/6/20 and 11/9/20 to reach FC #18's guardian were unsuccessful. There were no returned calls.

Interview on 10/6/20 with Counselor #2 revealed:
-if a client was not safe (had aggression toward self and/or others, had a problem being

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continuously monitored by staff and/or had elopement issues), there were varied safety methods a therapist (Counselor) or a member of the clinical team could authorize for a client's increased safety support;
-a client with physical aggression toward self and/or others were moved from the milieu to the basement to decrease the disruption in the team and not have the other clients impacted;
-the time a client spent in safety in the basement varied-it was meant to be a "temporary" period-48 to 72 hours.
-during that time, a client had one-on-one staff supervision, received their meals, medications, and hygiene in that location, and had written assignments to complete- their accountability and impactletters related to their problematic safety behavior(s) and their individual safety plan;
-removal from safety from the basement for return to the milieu was authorized by a client's Counselor and/or member of the clinical team;
-it had been a long time since she had been in the basement of the facility and did not know the last time she was in this location;
-she acknowledged that clients got scared when they saw a peer screaming and staff having to remove the peer from the milieu (to the basement);
-Client physical RIs were used in emergency situations to increase safety.

Interview on 9/24/20 with the Program Director revealed:
-there was a code key lock on the door at top of the stairs that prevented clients from going into the basement without staff;
-she confirmed that client safety in the basement was used for clients who had self-harming or aggressive behaviors;
-during this time, a client had safety assignments

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V 522	Continued From page 140 and was supposed to be verbally processing with their therapist; -this safety method was authorized by a client's therapist and could be increased to 48 hours; -a client had to be reassessed by her therapist before she returned to the milieu; -if she was in the basement over 72 hours, a client needed to be assessed by her treatment team for a decision of possible hospitalization. Interview on 12/1/20 with Executive Director, Founder, Clinical Director, Program Director and Operations Director revealed: -they were working on aligning their RI policies to comply with the rules; -they were unaware of the requirement about further documentation to authorize RIs beyond 15 minutes; -that would be a "quick fix." This deficiency is cross referenced into 10A NCAC 27E .0101 Least Restrictive Alternative (V513) for a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 522		
V 524	27E .0104(e12-16) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (12) The use of a restrictive intervention shall be discontinued immediately at any indication of risk to the client's health or safety or immediately after the client gains behavioral control. If the client is	V 524	V524: Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control: Facility failed to notify the legally responsible person of the minor clients immediately when a restrictive intervention was utilized Solstice East's Governing Body reviewed Tag V524 and gave direction for the following corrections, preventative measures and ongoing monitoring to take place: Correction: In-service trainings addressed areas of deficiencies in immediate notification of parent/guardian during use of restrictive intervention: 1. Residential on-call staff on 12/1/20 2. Clinical staff on 12/7/20	

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V 524	Continued From page 141 unable to gain behavioral control within the time frame specified in the authorization of the intervention, a new authorization must be obtained. (13) The written approval of the designee of the governing body shall be required when the original order for a restrictive intervention is renewed for up to a total of 24 hours in accordance with the limits specified in Item (E) of Subparagraph (e)(10) of this Rule. (14) Standing orders or PRN orders shall not be used to authorize the use of seclusion, physical restraint or isolation timeout. (15) The use of a restrictive intervention shall be considered a restriction of the client's rights as specified in G.S. 122C-62(b) or (d). The documentation requirements in this Rule shall satisfy the requirements specified in G.S. 122C-62(e) for rights restrictions. (16) When any restrictive intervention is utilized for a client, notification of others shall occur as follows: (A) those to be notified as soon as possible but within 24 hours of the next working day, to include: (i) the treatment or habilitation team, or its designee, after each use of the intervention; and (ii) a designee of the governing body; and (B) the legally responsible person of a minor client or an incompetent adult client shall be notified immediately unless she/he has requested not to be notified. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the legally responsible person of minor clients immediately when a restrictive intervention was utilized for 3 of 11 current audited clients (Client #4, Client #5 and	V 524	Continued From page 141 Implemented Restrictive Intervention Report to be completed by on-call supervisor or designee when RI is utilized. The report includes documentation of date/time of person(s) notified including parent/ guardian by primary therapist or qualified designee Prevention and Monitoring: Weekly audits to monitor and prevent future deficiencies in the area of immediate notification of parent/guardian when restrictive intervention is utilized focused on: 1. Incident reports (including use of RI) by Program Director or qualified designee 2. Restrictive interventions by Clinical Director or qualified designee and verified by Executive Director or designee If deficiencies are noted in the above audits, the following action plans will be implemented until substantial compliance is achieved as determined by the Governing Body: 1. Performance evaluations of staff Identified and continued training of staff 2. Documentation of in-services provided or plan for improvement Auditing will continue per above plans until substantial compliance is met and maintained as directed by the Governing Body.	

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V 524	Continued From page 142 Client #9) and for 1 of 7 former audited clients (FC #16). The findings are: Refer to tags V112, V513 and V522 for additional information. Review on 10/12/20 of Client #4's written incident reports revealed: -6/7/20 report of self-harm behavior (self-report she drank 4 large gulps of shampoo) occurred at 8:45 pm, and her guardian was notified of the incident the next day at 10:00 am; -she was placed on safety measures that included isolated time-out (sleeping in the common area for overnight supervision); -7/29/20 report of self-harm behavior (she drank mouthwash) occurred at 11:48 pm and her guardian was not notified of this incident; -7/30/20 report of self-harm behavior (banged head against wall and floor in bathroom and was restrained by staff) that began at 11:43 pm with documentation her guardian was notified at unknown time on 7/31/20; -the notifications to her guardian were made by her primary therapist; -there was no additional information documented as to the responses of her guardian to each of the above incidents. Review on 10/12/20 of Client #5's written incident reports revealed: -4/11/20 report of her attempted elopement with RIs that changed based on her cooperation and lasted about 5 hours total indicated a guardian was notified of this incident on 4/13/20 at an unknown time. -4/14/20 had 2 separate incidents (1st incident was at 2:13 pm and the 2nd incident was at 7:11 pm) of attempted elopements by Client #5 that led to her RIs.	V 524		

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V 524	Continued From page 143 -both her guardians were notified of the 2:13 pm incident on 4/24/20 at an unknown time; -one of her guardians was notified of the 7:11 pm incident on 4/18/20 at an unknown time; -notifications to the guardians were made by her primary therapist. -8/10/20 report of an attempted exit from a room after she walked into the room where Staff #19 observed her crying, breathing "heavily", was not communicating and she unaware of her surroundings; -"No answer" was marked as a response to the report question "Was the family notified?" -no additional information was provided with the report that indicated whether her family was notified by her therapist or another staff. Review on 10/15/20 of a 4/25/20 written incident report for Client #9 revealed: -no evidence her guardian was not notified of this incident. Record review on 9/30/20 of incident dated 3/28/20 regarding Former Client (FC) #16 revealed: -no documentation that the guardian was immediately notified of incident. Interview on 11/10/20 with FC #16's guardian revealed: -FC #16 did not complete treatment at the facility. She felt pleased with their services but did not recall specific incidents. -FC #16 killed herself 2 weeks earlier at another facility. Interview on 9/29/20 with the Program Director revealed: -each client's therapist had the responsibility for notifying a client's guardian when there was a	V 524		

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V 524	Continued From page 144 client incident related to their safety; -most of the time, clients stayed in the milieu and separated if there was physical or emotional unsafety that impacted the other clients or required a physical intervention; -did not consider the basement to be secluded-was a "high traffic area" that included a laundry area, staff kitchen, and mail room; -the client bedroom door was always opened. This deficiency is cross referenced into 10A NCAC 27E .0101 Least Restrictive Alternative (V513) for a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 524		
V 539	27F .0102 Client Rights - Living Environment 10A NCAC 27F .0102 LIVING ENVIRONMENT (a) Each client shall be provided: (1) an atmosphere conducive to uninterrupted sleep during scheduled sleeping hours, consistent with the types of services being provided and the type of clients being served; and (2) accessible areas for personal privacy, for at least limited periods of time, unless determined inappropriate by the treatment or habilitation team. (b) Each client shall be free to suitably decorate his room, or his portion of a multi-resident room, with respect to choice, normalization principles, and with respect for the physical structure. Any restrictions on this freedom shall be carried out in accordance with governing body policy. This Rule is not met as evidenced by:	V 539	V539: Living Environment: Facility failed to provide an atmosphere conducive to uninterrupted sleep during scheduled sleep hours Solstice East's Governing Body reviewed Tag V539 and gave direction for the following corrections, preventative measures and ongoing monitoring to take place: Correction: Safety Phase policy updated such that sleep observation may be utilized when clinically indicated for the purpose of the client's safety or safety of others, but is no longer mandatory. When clients are required to sleep in the common area (sleep observation) due to therapist assessment that they may be harmful to self or others, staff should collaboratively provide options to the client that may assist in providing an atmosphere that is both comfortable and conducive to uninterrupted sleep. In-service trainings addressed above policy update and means for implementation: 1. Residential on-call staff on 12/1/20 2. Residential direct care staff on 12/15/20, including documentation in shift note of sleep observation intervention and communication with client regarding options identified above 3. Clinical staff on 12/7/20	

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V 539	Continued From page 145 Based on record review, observation and interview, the facility failed to provide an atmosphere conducive to uninterrupted sleep during scheduled sleep hours for 6 of 11 current clients (Client #3, #4, #5, #8, #9, #10) and for 2 of 7 former clients (FC #13, FC #14). The findings are: Refer to tags V112 and V513 for additional information. Observation on 9/24/20 at 11:30am revealed: -the Dorm and the Lodge were residential buildings. The current census in the Dorm was 10 girls. Bedrooms had 2 bunk beds along one wall with a bathroom/shower. Staff area was central in the large activity room with dining as well as glass enclosed group area. Bedrooms, medication room, art/group rooms were also off of the large common area. -the Lodge was an older larger building that contained 2 residential floors. Both floors had a central common area with bedrooms and a group room off of the main area. Bedrooms had 2 bunk beds on one side of the room along with a bathroom/shower. The main floor contained the dining room/kitchen and medication room along with residential bedrooms. The lower level or basement had an observation/isolation bedroom with 1 bed and bathroom/shower, a den with couch, chairs, and a table. Both of these rooms were off of a small common area. Staff mail room, staff kitchen, IT (information technology) office, neurofeedback office and student laundry were also off of this common area. Record review on 10/9/20 for Client #3 revealed: - a 2-page printed staff shift note document dated in 9/2020 for Client #3 revealed: -the document included multiple note entries that	V 539	Continued From page 145 Prevention and Monitoring: Weekly audits to monitor and prevent future deficiencies in immediate notification of parent/ guardian when restrictive intervention is utilized, which include: 1. Incident reports (including use of RI) by Program Director or qualified designee 2. Shift notes by Program Director or qualified designee 3. Restrictive interventions and precautions by Clinical Director or qualified designee, and verified by Executive Director or qualified designee If deficiencies are noted in the above audits, the following action plans will be implemented until substantial compliance is achieved as determined by the Governing Body: 1. Performance evaluations of staff 2. Identified and continued training of staff 3. Documentation of in-services provided or plan for improvement Auditing will continue per above plans until substantial compliance is met and maintained as directed by the Governing Body.	

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V 539	Continued From page 146	V 539		

ranged in date from 9/1/20 to 9/15/20;
-a residential team manager(Staff #34)'s name was printed at the top of the note;
-9/3/20's entry included Client #3 still slept in the common area and needed to be at arm's length of staff. She was still a "run risk."
-Review of printed emails dated 9/14/20 between Client #3's therapist and Staff #34 and Staff #35 revealed a decision was made for Client #3 to return sleeping in her own room before she was taken off additional safety precautions and run risk.

Interview on 11/2/20 with Client #3 revealed:
-she slept in the common area of the facility where she was watched by overnight staff. Although lights were turned off at 9:45 pm, she had difficulty sleeping in the common area as staff walked in and out of the room through the night.

Record review on 10/12/20 for Client #4"s monthly team meeting notes from 4/1/20 to 8/11/20 revealed:
-the psychiatry section of the notes indicated she struggled with sleep;
-4/1/20- she was prescribed a low-dose melatonin for sleep;
-6/9/20- she was started on Clonidine for sleep.
-review of incident report dated 6/7/20 for Client #4 revealed her bed was moved into the common area as a safety precaution and a result of a self-harm incident;
-there was no additional information that identified possible sleeping alternatives to address Client #4's known difficulties with sleep.

Attempted interview between 10/29/20 and 11/3/20 with Client #4's guardian revealed no response. There were no returned calls.

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V 539	Continued From page 147 Record review on 10/12/20 for Client #5 revealed: -review of a printed email dated 6/15/20 sent from Staff #34 to 4 separate named staff groups about Client #5 revealed her safety phase included sleeping in the common area. Record review on 11/17/20 for Client #8 revealed: -Review on 10/22/20 of printed facility shift notes dated 8/24/20 and 8/28/20 about Client #8 revealed: -her safety phase included sleeping in the common area. -review of monthly psychiatric visit notes for the period from 5/4/20 to 10/6/20 revealed: -entries dated 5/4/20, 6/9/20, and 8/11/20 included her self-reports she was sleeping well. These notes identified her prescribed medication was a bedtime supplement as needed (PRN) for sleep; -entry dated on 10/6/20 included her self-report of difficulty sleeping and her guardian's consent for Trazadone for sleep. Interview on 11/3/20 with Client #8 revealed she had difficulty sleeping in the common area with the lights on which led her to being prescribed Trazadone, as needed (PRN) for sleep. Prior to this medication for sleep, she took an herbal supplement, PRN for help with sleep. Record review on 10/15/20 for Client #9 revealed: -review of facility shift note dated 5/3/20 and completed by Staff #34 for Client #9 revealed she was on safety precautions which included her sleeping in the common area. Interview on 11/3/20 with Client #9 revealed: -safety in the common area was for clients who were not trying to run away or self-harm but	V 539		

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V 539	Continued From page 148 needed staff overnight supervision. Record review on 10/16/20 of Client #10's record revealed: -a written note dated 9/29/20 in her individual therapy session notes indicated she was provided a behavioral intervention known as "Self-Focus" (she stayed verbally silent except to speak to staff about needs such as food and bathroom, was required to stay within 10 feet of staff, and she was given reading and written assignments to complete and which addressed her recent "unhealthy" behaviors). Interview on 11/2/20 with Client #10 revealed: -she slept in the common area overnight as a safety precaution intervention which lasted 48 hours. Record review on 10/2/20 for FC #13 revealed: -an admission date of 1/24/19, discharge date of 5/12/20. Interview on 11/6/20 with FC #13 revealed: -was on safety a few times- no talking- in hand book/student manual -1 safety was put in basement- dysregulation- not allowed to leave bedroom- therapist would talk to you through staff- was only there 1 night- no outside- had meals there- knew of others there 2-3 weeks -longest time she was on safety was 5 days-slept in common area -others "on safety a LONG time". Record review on 9/28/20 for FC #14 revealed: -an admission date of 10/24/18, discharge date of 4/6/20. Interview on 11/6/20 with FC #14 revealed:	V 539		

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V 539	Continued From page 149 -was on safety multiple times- communication block-didn't really understand what I was doing wrong; -some put on safety for stupid reasons; -no time to yourself-have to be within arms- slept in common area; -was not a risk to herself or others-didn't understand why she had to sleep in common area. Interview on 11/3/20 with the Executive Director revealed: -the physical design of the residential building where clients had their bedrooms was not conducive for continuous monitoring by overnight staff to ensure client safety; -the common area for clients to sleep allowed clients who had unsafe behaviors and were on Safety (Safety Phase or Safety precautions) to be continuously monitored by overnight staff. Interview on 12/1/20 with Executive Director (ED), Founder, Clinical Director, Program Director and Operations Director revealed: -an expressed interest in pursuing a waiver for clients to be permitted to sleep in the common area; -expressed concern that time of a requested waiver and an appeal would place the facility outside the 23-day correction period; -interim methods were identified to address clients' difficulty sleeping and included eye masks and ear plugs; -The ED remarked they did not want the common area to be "too comfortable" for clients. This deficiency is cross referenced into 10A NCAC 27E .0101 Least Restrictive Alternative (V513) for a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 539		

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