Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601227	A. BUILDING: ______ B. WING ______	12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERANCAS COTTAGE	**6750 SAINT PETERS LANE, SUITE 300 MATTHEWS, NC 28105**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint survey was completed on 12-23-20. The complaint was substantiated (#NC00171888). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G 1900 Psychiatric Residential Treatment Facility.	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional.	V 110	V110/V314- Program Supervisor is responsible for completion of the following: 1. All staff in Merancas cottage including the Floor Supervisor has reviewed and signed the vehicle use policy as well as resubmitted current drivers license. 2. All staff in Merancas including the Floor Supervisor have been re-trained in de-escalation strategies to ensure appropriate knowledge, skills and abilities are demonstrated while in ratio. 3. The Residential Care Specialists and the Floor Supervisor has received training in the core skill capacities in their monthly individual and/or group supervision provided by the Program Supervisor specific to decision-making and communication in regards to client safety. 4. All Merancas Residential Care Specialists have reviewed and signed current client Person Centered Plans to ensure appropriate interventions are used as outlined in the Crisis Plan.	12/26/2020 1/22/2021 1/31/2021 1/31/2021

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Hannah Dunham
TITLE: Chief Performance & Quality Officer
(X6) DATE: 1/21/2021

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V 110	Continued From page 1	V 110		

This Rule is not met as evidenced by:
Based on interviews and record reviews, one of one Floor Supervisor failed to demonstrate knowledge, skills, and ability required by the population served. The findings are:

Review on 12-16-20 of the Floor Supervisor's record revealed:
-Hire date of 3-13-18.
-Training's include: Defensive Driving, the basics 5-1-18, PRTF (Psychiatric Residential Treatment Facility) rules and service 5-6-18, TCI (Therapeutic Crisis Intervention) behavior support techniques 8-6-20.

Review on 12-3-20 of IRIS (Incident Response Improvement System) dated 11-10-20 of incident dated 11-9-20 revealed:
-"[Former Client #1] (FC#1) got upset and started punching the seat and kicking the doors. Staff (Staff #1) asked client to stop to no avail, and [FC#1] suddenly got up out of his seat and charged at staff member who was driving the van. Staff was startled and she hit the brakes, causing [FC#1] to lunge forward and he hit his forehead on the windshield. [FC#1] responded by punching staff on the face and side once the van came to a complete stop... Staff took [FC#1] to [local children hospital] to access for head trauma and he was seen around 7:30 pm. He was diagnosed with a 'mild concussion'. [FC#1] returned to the cottage shortly thereafter..."

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V 110	Continued From page 2	V 110		

Interviews on 12-6-20 and 12-15-20 with Staff #1 revealed:
-Before they left the cottage on 11-9-20 she explained to the Floor Supervisor that she didn't feel comfortable transporting FC#1 by herself.
-The school is on the campus grounds.
-The day of the incident (11-9-20) they left for school and one client had to stay back at the cottage.
-"I was explaining to the Floor Supervisor that I didn't feel comfortable taking the other five. (Clients by herself). I think it was five, if not then four."
-"I told the Floor Supervisor, she said, 'that is what we do.'"
-"My thing is it was a traumatic experience for me. I don't know the ins and outs how they run things in upper campus, but [another cottage] doesn't transport with one staff.. When I first worked, I worked upper campus and we used two staff to transport."
-"I've seen how [FC#1] attacks certain staff, I don't want to be on the end of that."
-"I feel like he (FC#1) targets females quicker than males. He targets staff that follows the schedule, he doesn't like routine, he doesn't like structure."
-"He can become aggressive so quickly and sometimes it is nothing that sets him off. He can look at you and that gets him upset."
-Staff #1 reiterated again that the Floor Supervisor told her that she would have to transport the clients by herself and "I couldn't go back and forth with my supervisor."
-"[Staff #2] was left alone, but she heard me tell [Floor Supervisor] I didn't feel comfortable."
-Staff #2 also did not feel comfortable transporting FC#1 by herself.
-The facility was short staffed so there was no one else to take the clients to school.

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V 110	Continued From page 3	V 110		

-She thought perhaps the Floor Supervisor was working direct care at another cottage so that is why she couldn't help with transportation.
-"They are really short staffed. I am no longer there. It was too much.
-"[Floor Supervisor] might not have felt comfortable taking [FC#1]. He had just attacked her and bit her. I don't know if she didn't feel comfortable either or didn't want to be alone with him."

Interview on 12-6-20 with Staff #2 revealed:
-She thought that one staff could have up to three clients by themselves when transporting them.
-Staff #1 had told the Floor Supervisor that she didn't feel comfortable transporting FC#1 by herself.
-"She (Staff #1) specifically told her (Floor Supervisor) at the table (kitchen table at cottage)."
-FC#1 had attacked Staff #1 before.
-The Floor Supervisor "told her (Staff #1), that is what happens when ever someone has to stay back, we have to transport alone."
-"She (Staff #1) definitely told the supervisor (Floor Supervisor) she didn't want to transport him by herself."

Interview on 12-11-20 with the Floor Supervisor revealed:
-Her job is "right below a regular supervisor, I do the same things relating to the cottage and working staff."
-She had repeatedly gone over to the cottage of FC#1 the morning of 11-9-20 because, "He was struggling and needed assistance."
-When asked why Staff #1 was transporting clients by herself: "They had another kid, I can't remember why he had to stay back...One staff

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V 110	Continued From page 4 had to stay back." -"They took the van in order to make the transition smoother, she wanted to be sure she wasn't out of ratio too long. That means by herself. I think with five kids we are at a 3:1 ratio." -Staff #1 has told her that she was uncomfortable "in the cottage in general." -"She (Staff #1) has communicated she is uncomfortable with [FC#1]. She has told me that before." -After the incident: "She (Staff #1) was very distressed about the situation. She was upset. She felt like it put her at risk and the other kids." -There were two staff per cottage. "The one person would be out of ratio for the transitioning." -"We don't notify [Program Supervisor] if we have to transition to make things go smoothly. There have been times I transition 4-5 kids if someone has to stay back." -FC#1 was not at his baseline behaviors and she doesn't know why Staff #1 and Staff #2 chose Staff #1 to transport the clients. This deficiency is cross referenced into 10A NCAC 27G .1901 Scope (V314) for a Type A1 rule violation and must be corrected within 23 days.	V 110		
V 314	27G .1901 Psych Res. Tx. Facility - Scope 10A NCAC 27G .1901 SCOPE (a) The rules in this Section apply to psychiatric residential treatment facilities (PRTF)s. (b) A PRTF is one that provides care for children or adolescents who have mental illness or substance abuse/dependency in a non-acute inpatient setting. (c) The PRTF shall provide a structured living environment for children or adolescents who do	V 314		

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V 314	Continued From page 5 not meet criteria for acute inpatient care, but do require supervision and specialized interventions on a 24-hour basis. (d) Therapeutic interventions shall address functional deficits associated with the child or adolescent's diagnosis and include psychiatric treatment and specialized substance abuse and mental health therapeutic care. These therapeutic interventions and services shall be designed to address the treatment needs necessary to facilitate a move to a less intensive community setting. (e) The PRTF shall serve children or adolescents for whom removal from home or a community-based residential setting is essential to facilitate treatment. (f) The PRTF shall coordinate with other individuals and agencies within the child or adolescent's catchment area. (g) The PRTF shall be accredited through one of the following; Joint Commission on Accreditation of Healthcare Organizations; the Commission on Accreditation of Rehabilitation Facilities; the Council on. Accreditation or other national accrediting bodies as set forth in the Division of Medical Assistance Clinical Policy Number 8D-1, Psychiatric Residential Treatment Facility, including subsequent amendments and editions. A copy of Clinical Policy Number 8D-1 is available at no cost from the Division of Medical Assistance website at http://www.dhhs.state.nc.us/dma/. This Rule is not met as evidenced by: Based on record review and interviews the facilty	V 314		

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V 314	Continued From page 6	V 314		

failed to provide supervision and staffing to ensure safety of the clients. The findings are:

Cross Reference: 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110); Based on interviews and record reviews, one of one Floor Supervisor failed to demonstrate knowledge, skills, and ability required by the population served.

Cross Reference 10A NCAC 27G .1902 Staff (V315); Based on record review and interview the facility failed to ensure that two direct care staff were present with every six children.

Review on 12-23-20 of first Plan of Protection dated 12-23-20 signed by the Quality Improvement Specialist revealed:

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

"-The consumer involved in this particular incident discharged on 11-24-20. Thompson (Licensee) submitted a 30 day discharge notice to his MCO (Managed Care Organization) due to concern with his high acuity.
-Thompson will continue to ensure Merancas cottage is meeting staffing ratios at all times.
-Thompson will adhere to our internal transportation policy at all times, even when transporting clients on campus."

Describe your plans to make sure the above happens.

-"Thompson's will immediately communicate with Merancas PRTF (Psychiatric Residential Treatment Facility) staff on 12-22-20 regarding the above transportation policy."

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V 314	Continued From page 7	V 314		

Review on 12-23-20 of second Plan of Protection dated 12-23-20 and signed by the Quality Improvement Specialist revealed:

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

"-The consumer involved in this particular incident discharged on 11-24-20. Thompson (Licensee) submitted a 30 day discharge notice to his MCO (Managed Care Organization) due to concern with his high acuity.
-Thompson will continue to ensure Merancas cottage is meeting staffing ratios at all times.
-Thompson will adhere to our internal transportation policy at all times, even when transporting clients on campus.
-Program Supervisors will continue to meet with direct care staff about client safety and behavioral concerns through individual and/or group supervision.
-Program Supervisors will continue to provide support/training/coaching of TCI (Therapeutic Crisis Intervention) and CARE techniques to help direct care staff feel confident in their crisis de-escalation and intervention skills as well as relationship building with clients."

Describe your plans to make sure the above happens.

-"Thompson's will immediately communicate with Merancas PRTF staff on 12-22-20 regarding the above transportation policy.
-Program Supervisors/Therapists will continue to discuss client specific needs and interventions during Cottage staff meetings and supervisions.
-Continue TCI training and refreshers."

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V 314	Continued From page 8 Former Client #1 is a thirteen year old with Disruptive Mood Dysregulation Disorder. He has a long history of aggression, with several recent incidents of attacking staff. His goals include; utilize positive coping skills by verbalizing his feelings, handle peers in a healthy way, staff will assist will review basics of treating others with respect, assist in identify positive consequences of managing frustrations and anger; develop coping skills to deal with anxiety will assist with healthy self-talk as means of handling anxiety; develop ability to control impulses. Both staff and clients reported that FC#1 can be unpredictable and can escalate quickly. He had been agitated that morning and the Floor Supervisor had to come to Merancas cottage and help redirect him several times the morning of the incident. The Floor Supervisor made the decision to have Staff #1 transport Former Client #1 and three other clients by herself, despite Staff #1 telling her she did not want to be with Former Client #1 by herself due to his aggressive behaviors. Both staff and clients reported that multiple clients were often transported with one staff. On 11-9-20, during the transportation ride from the on campus school to the cottage, Former Client #1 became upset and attacked staff, resulting in Staff #1 suddenly hitting her brakes and Former Client #1 being thrown into the windshield, resulting in a concussion. Due to lack of required staffing and lack of knowledge, skills and ability demonstrated by the Floor Supervisor, this constitutes a Type A1 for harm and neglect and must be corrected within 23 days. An administrative penalty of 2,000 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty on 500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 314		

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V 315	Continued From page 9	V 315		
V 315	27G .1902 Psych. Res. Tx. Facility - Staff 10A NCAC 27G .1902 STAFF (a) Each facility shall be under the direction a physician board-eligible or certified in child psychiatry or a general psychiatrist with experience in the treatment of children and adolescents with mental illness. (b) At all times, at least two direct care staff members shall be present with every six children or adolescents in each residential unit. (c) If the PRTF is hospital based, staff shall be specifically assigned to this facility, with responsibilities separate from those performed on an acute medical unit or other residential units. (d) A psychiatrist shall provide weekly consultation to review medications with each child or adolescent admitted to the facility. (e) The PRTF shall provide 24 hour on-site coverage by a registered nurse. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure that two direct care staff were present with every six children. The findings are: Review on 12-4-20 of Former Client #1's record revealed: -Admitted 11-25-19, discharged 11-27-20. -13 years old. -Diagnosis of Disruptive Mood Dysregulation Disorder. -Person Centered Plan last updated 11-17-20 revealed: He has a long history of aggressive behaviors and multiple hospitalizations. Goals	V 315	V315/V314- 1. Floor Supervisor will continue to ensure at least 2 direct care staff are scheduled to be present in the residential unit at all times to ensure appropriate client to staff ratio. 2. Floor Supervisors publish staff schedules monthly on the 26th. 3. Floor Supervisors and/or Program Supervisor will ensure the 2:6 ratio is met at all times, whether on transport in the van or not, through monitoring of the schedule and milieu.	Completed 12/26/20 and ongoing monthly. Monthly Daily

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V 315		V 315		

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include; utilize positive coping skills by verbalizing his feelings, handle peers in a healthy way, staff will assist will review basics of treating others with respect, assist in identify positive consequences of managing frustrations and anger; develop coping skills to deal with anxiety will assist with healthy self-talk as means of handling anxiety; develop ability to control impulses.

-Psychiatric Evaluation dated 11-29-19 revealed: History of aggression in the home to his brother, his mother and a neighbor.

Review on 12-16-20 of a policy entitled "Driving and Use of Agency Vehicles" dated 10-4-19 revealed:

-"Transporting clients; Appropriate staff to client ratios must be maintained when transporting clients."

Review on 12-22-20 of an email addressed to facility staff dated 12-22-20 revealed:

-"ATTENTION: Please be sure to adhere to TCFF's (Thompson Child & Family Focus) Driver Agreement Form and Driving & Use of Agency Vehicles policy, which will be provided for all staff to review and sign. We must ensure that appropriate staff to client ratios are maintained every time we are transporting kids in a vehicle (on or off campus). Prior to entering the vehicle, be sure to review vehicle safety expectations and ensure that all clients are at baseline before transport begins..."

Review on 12-7-20 of undated and unsigned summary of information regarding the incident on 11-9-20 revealed:

- "Former Client #1 (FC#1) was about to get on the van from school as he started dancing inappropriately in attempts to get attention from his female peers from another cottage. Staff

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(Staff #1) redirected [FC#1] and asked him to load the van. [FC#1] got on the van and asked staff if she was mad at him. Staff responded by saying,'No' and preceded to drive back to the cottage. [FC#1] asked if staff could stop by the administration office and staff told him that they were returning to the cottage. [FC#1] got upset and started punching the seat and kicking the doors. Staff asked client to stop to no avail, and [FC#1] suddenly got up out of his seat and charged at the staff member who was driving the van. Staff was startled and hit the brakes, causing [FC#1] to lunge forward and he hit his head on the windshield. [FC#1] responded by punching staff in the face and side once the van was at a complete stop. He eventually stopped and returned to the cottage."

-"Staff took [FC#1] to [local hospital's emergency department] to assess for head trauma and he was seen around 7:30pm. He was diagnosed with a 'mild concussion'. [FC#1] returned to the cottage shortly thereafter and went to sleep."

-"Incident Prevention: Staff will validate [FC#1]'s feelings when he is upset, wait until he is calm, and make sure he understands expectations of vehicle safety before starting the van. Staff involved will be retrained on the vehicle operation policy."

Review on 12-8-20 of unsigned document dated 11-9-20 with both Staff #1 and the Program Supervisor's name typed in the heading revealed:

-"Debriefing: On Monday, November 9th, I met with [Staff #1] around 2pm and we discussed the incident that took place on the van with [FC#1]. She gave me the details of the incident and we reviewed [Licensee]'s Vehicle Operating Policy. We reviewed [FC#1]'s Crisis Plan and encouraged her to validate [FC#1]'s feelings

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V 315	Continued From page 12	V 315		

when he is upset, wait until he is calm, and make sure that he understands expectations of vehicle safety before starting the van. She expressed to me that she 'didn't feel safe working with with client [FC#1] because of his unpredictable and aggressive behaviors.' I granted her permission to work in another cottage until client discharges and to take some time off. She agreed to re-take the driver's test once she returns to work before transporting clients in an agency vehicle. Her driver's test is scheduled for December 16, 2020."

Review on 12-3-20 of IRIS (Incident Response Improvement System) dated 11-10-20 of incident dated 11-9-20 revealed:
-FC#1 was "dancing" around trying to get female peers attention. He was redirected to load the van, leaving school. FC#1 had wanted to stop at the administration building and was told they were going back to the cottage. "[FC#1] got upset and started punching the seat and kicking the doors. Staff (Staff #1) asked client to stop to no avail, and [FC#1] suddenly got up out of his seat and charged at staff member who was driving the van. Staff was startled and she hit the brakes, causing [FC#1] to lunge forward and he hit his forehead on the windshield. [FC#1] responded by punching staff on the face and side once the van came to a complete stop. He eventually stopped and returned to the cottage. Staff took [FC#1] to [local children's hospital] to assess for head trauma and he was seen around 7:30 pm. He was diagnosed with a 'mild concussion'. [FC#1] returned to the cottage shortly thereafter..."

Review on 12-8-20 of other IRIS reports for FC#1 from 10-12-20 to 11-7-20 revealed:
-10-12-20: ..."[FC#1] refused to accept staff's decision and struggled to appropriately express

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himself as he started yelling, cursing, and threatening staff. ...paced around the cottage making threats...threw down a computer in the day area and broke it...threw a board game at staff...attempted to knock down a bookshelf, which caused a large piece of wood to break off. [FC#1] immediately grabbed the wood and threatened to hit staff in the face with it....repeatedly banged on the security alarm, door and the windows shattering it with the wood...paced around with two large pieces of wood in his hands..threatened to attack staff with the wood...broke the door handle with the wood piece and ran out the door."

-10-19-20: ..."Client (FC#1) became very impatient because he felt he had nothing to do inside...picked up the cottage phone and started calling random people that were stored in the phone...then threw the cottage cell phone. Staff walked with [FC#1] to his room as he was becoming aggressive (hitting staff and attempting to fight peer). and destructive...[FC#1] began cursed at staff and communicating threats towards staff...[FC#1] continued to escalate and began throwing big shelf blocks...he took a slab off the bookshelf and struck staff in the head..."

-11-7-20: "While outside [FC#1] began antagonizing (throwing footballs at the window, cursing at and calling them names) another cottage....When staff asked him to stop he began cursing and communicating threats to staff. Staff switched out with another staff in efforts to assist [FC#1] with calming down....When [FC#1] came inside he asked staff if he could watch a movie. When staff let [FC#1] know he would not be changing the days schedule he began cursing and making negative comments towards staff. Staff prompted [FC#1] to redirect. [FC#1] continued to escalate by pulling wood and nails off the door...When staff began unplugging the

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television, [FC#1] ran behind staff and attempted to strike staff with the wood."

Review on 12-9-20 of Staff #1's Training revealed:
-TCI (Therapeutic Crisis Intervention) 11-4-20, Therapeutic Boundaries 3-30-20, Defensive Driving 11-30-18.

Interview on 12-11-20 with FC#1 revealed:
-Staff #1 was the only staff on the van.
-He couldn't remember exactly who was on the van but "I think it was all of us" (The rest of the clients from his cottage.)
-He denies that he hit Staff #1; " I would never hit a girl."
-He had been angry and wanted to get off the van. Staff #1 wouldn't let him. She was holding him with one hand to stop him and he fell into the windshield.
-He then got out of the van and the Floor Supervisor helped to the cottage.
-The nurse assessed him and when he told them (nurse and Merancas cottage staff) he had a headache they took him to the doctor where they told him he had a concussion.
-He had problems with Staff #1 before; "I never really liked her, she is very slick, she will cuss."

Interview on 12-11-20 with Former Client #2 revealed:
-They had left school and Staff #1 told them that they would not be stopping at the administration building.
-"[FC#1] got mad, I was talking with friends."
-"He (FC#1) got up out of his seat, I saw him hit her (Staff #1)."
-"Then something else happened. I think she

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hit the brakes, he (FC#1) went into the windshield. Then he (FC#1) got out of the van."
-Staff #1 was driving the van.
-Staff #1 was a regular staff, but not a regular at that cottage, but she had worked there several times before.
-Staff #1 was working by herself when the incident happened.
-"It happened before that one staff took five or six, I don't think they ever went off campus by themselves."
-FC#1 had been upset, happy and angry that morning.
-Staff at the facility treat them well.

Interview on 12-3-20 with Client #3 revealed:
-"He (FC#1) wanted to get out, she (Staff #1) slammed the brakes."
-"He (FC#1) punched her (Staff #1) because he got a percussion (concussion)."
-"He (FC#1) hit staff (Staff #1). That's when she hit the brakes. He (FC#1) hit the top of his head."
-Client #3 did not know why FC#1 was angry.
-"[Staff #1] was by herself. Sometimes there is two staff, sometimes one."
-He has seen FC#1 hit other staff before.

Interviews on 12-6-20 and 12-15-20 with Staff #1 revealed:
-The day of the incident on 11-9-20 they left for school and one client had to stay back at the cottage.
-The school is on the campus grounds.
-"I was explaining to the Floor Supervisor that I didn't feel comfortable taking the other five. (Clients by herself). I think it was five, if not then four."
-"I told the Floor Supervisor, she said, 'that is what we do.'"

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-She was "fairly new" to that cottage but had seen FC#1 get aggressive before.
-She was there when FC#1 had tried to attack another client and she had used her body as a shield.
-The morning of the incident, she told FC#1 about the expectations on the van, to stay seated, with seatbelts on.
-FC#1 was in a good mood that morning.
-"He was in too good a mood if that makes sense. He was in a better mood that what I have seen."
-While at school FC#1 had to be redirected multiple times.
-When they were leaving school, FC#1 was dancing around and had to be redirected.
-She was still transporting the clients by herself.
-She had been planning on stopping at the administration building.
-"[FC#1] got mad out of nowhere. I don't know if it was me redirecting him, I don't know."
-"He (FC#1) was kicking the back of the seats and the doors."
-She told him that they couldn't stop at the administration building.
-"He started screaming, cussing me out. I ignored him."
-"We got to the stop sign, he (FC#1) gets out of his seatbelt and charges me. He fell towards the front of the van."
-"I hit the brakes when he (FC#1) started charging me. As he was lunging, I stopped."
-"He (FC#1) fell, he hit the windshield, It kinda looked like he threw himself (into the windshield)."
-"He (FC#1) hit the windshield, he started punching me in my head and arm. The side of my jaw and right arm."
-"He jumped out of the van and went running

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toward the upper campus."
-She had just pulled away from the stop sign, so she was going very slow.
-The Floor Supervisor and a staff from another cottage came out to the van and went with FC#1 to the cottage.
-Staff #1 called her Program Supervisor and the nurse came immediately and examined FC#1.
-"I wrote up what happened and submitted it. I didn't hear anything else. I had already told them I didn't feel safe working with [FC#1]."
-"My thing is it was a traumatic experience for me. I don't know the ins and outs how they run things in upper campus, but [cottage] doesn't transport with one staff.. When I first worked, I worked upper campus and we used two staff to transport."
-"I've seen how [FC#1] attacks certain staff, I don't want to be on the end of that."
-"I feel like he (FC#1) targets females quicker than males. He targets staff that follows the schedule, he doesn't like routine, he doesn't like structure."
-"He can become aggressive so quickly and sometimes it is nothing that sets him off. He can look at you and that gets him upset."
-She reiterated again that the Floor Supervisor told her that is what she would have to do and "I couldn't go back and forth with my supervisor."
-"[Staff #2] was left alone, but she heard me tell [Floor Supervisor] I didn't feel comfortable."
-Staff #2 also did not feel comfortable transporting FC#1 by herself.
-The facility was short staffed so there was no one else to take the clients to school.
-She thought perhaps the Floor Supervisor was working direct care at another cottage so that is why she couldn't help with transportation.

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-"They are really short staffed. I am no longer there. It was too much. Not enough staff, the supervisors don't speak up, they cover things up. For me it was when [Program Supervisor] said he had a meeting with me and he didn't."

-She had called the Program Supervisor on the phone to tell him what happened and that she needed to go home, but he said there was no staff to relieve her and "he strongly advised me not to leave."

-"He said that we would go over the vehicle operation policy when I returned."

-She and the Program Supervisor had not gone over any expectations for the van.

-"He (Program Supervisor) told me they were working on a plan to get [FC#1] discharged."

-"I did agree to retake the drivers test. But this didn't come until after you went in to speak to them. He then told me things were going to be put in place."

-"The same day it happened I told him about the incident. He came in the cottage and got the payroll book. At no point did he mention what happened. He was in and out."

-"The only thing that happened that day was I told him about the incident. I told him I needed a break, and asked if I could go home. I can't remember when I asked about moving."

-"[Floor Supervisor] might not have felt comfortable taking [FC#1]. He had just attacked her and bit her. I don't know if she didn't feel comfortable either or didn't want to be alone with him."

Interviews on 12-6-20 and 12-17-20 with Staff #2 revealed:

-She had to stay back at the cottage with two clients by herself.

-There were no issues with the clients she had to stay at the cottage with.

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-She saw FC#1 after he returned from the incident and he was saying how he had attacked staff and hit the windshield.
-She thought it was allowed that one staff could take three clients by themselves to school.
-The Floor Supervisor told Staff #1 that whenever a client has to stay back at the cottage, the other staff has to transport alone.
-FC#1 went to the doctor and was diagnosed with a concussion.
-"[Program Supervisor] did not speak to [Staff #1] that day. That is not true at all."
-"[Staff #1] was still in the cottage. [Program Supervisor] never spoke to her, at least not while I was there from 7am-3pm and [Staff #1] never left."
-She had also told the Program Supervisor she wasn't comfortable working with FC#1 because he bragged about getting a staff member fired and she did not feel like it was safe for only females to work with FC#1.
-On 12-17-20 she reported that she was still transporting clients by herself; "I had to do it today."

Interview on 12-11-20 with the Floor Supervisor revealed:
-She is the Floor Supervisor, "I'm right below a regular supervisor..."
-I was at [neighboring cottage], I had been going over there (cottage) since 8:00 (am). He was struggling and staff needed assistance. I would get him back to baseline and leave."
-She saw FC#1 run up to the front of the van.
-"She (Staff #1) was trying to stop, I saw him hit her."
-"When they stopped, he went head first into the window."
-She helped FC#1 back to the cottage and the nurse examined him.

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-"He has hit me several times (previously). I have marks all over my hands."
-When asked why Staff #1 was by herself: "They had another kid, I can't remember why he had to stay back, whether he was struggling or a flight risk."
-"One staff had to stay back."
-"At school there is plenty of staff, it was just the transitioning she was by herself."
-"They took the van in order to make the transition smoother. She wanted to make sure she wasn't out of ratio too long. That means by herself."
-"I think with five kids we are in a 3:1 ratio."
-"The one person would be out of ratio for the transitioning."
-The van was moving when FC#1 rushed to the front, but "maybe five miles an hour."
-Her supervisor was the Program Supervisor. They don't notify him if they have to transition so things go smoothly.
-"There have been times I transition four-five kids if someone has to stay back."
-"I know [FC#1] was struggling. That morning, I remember he was yelling, slamming doors getting in their (staff) faces."

Interview on 12-15-20 with school teacher revealed:
-FC#1 can escalate quickly.
-"Any little thing can set him off."
-"The ratio is 2:6 but sometimes, say, two staff but one kid needs to stay back, one staff will be with them."

Interview on 12-3-20 and 12-18-20 with the Program Supervisor revealed:
-"At the time, there was nobody else. ..Normally when kids have to hold back there are no issues."

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-The cottage had two clients that couldn't go to school that day.
-"We figured it would be OK to transport."
-When asked about the transportation policy: "At the time we figured that it would be the best way to transport the kids."
-He met with Staff #1 in his office that day. "I wrote it up...We talked about the incident. It was more of an informal conversation....We set it up to where she was coming back on the 16th but up to this point she has not returned....That was when we were going to go over the vehicle policy."
-"It was that day we talked about [FC#1] and the best way to deal with him."
-"Normally it is two people on the van. We are short staff right now, we are down a couple staff across the board."
-"Just to clarify, we are short staff but we still had two staff working with the kids. We weren't down staff, it wasn't like we didn't have the normal amount of staff for that day."
-Nobody had informed him that they would be splitting the staff to transport to school.
-Staff #1 and Staff #2 were working that shift. "It was just for one hour (That staff were split). [Staff #1] took the others. I guess they thought to take the van would be faster."

Interview on 12-15-20 with the Chief Program Officer revealed:
-He was not involved with the decision to have one staff.
-"Every good plan can go sideways. He was transported like that because he could have had an AWOL (Absent Without Leave)."
-"We felt we were in a double bind." In a PRTF situation the zero risk option is not always the best from client right standpoint.
-"In this issue, he wasn't on the van by

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accident, it was to prevent AWOL."
-"It is a really tough situation. I do get worried about unintended consequences."
-"I reviewed it pretty thoroughly, these things can happen with this population."
-"Bad things can happen in good facilities."
-"In this, I felt like we took everything into consideration."
-"Particularly with that staff member (Staff #1)...we sometimes lose really good staff because they think they might be terminated or reprimanded for something they didn't have a choice in."
-"This time we really thought we had done due diligence. Sometimes even good staff are involved in tough situation."

This deficiency is cross referenced into 10A NCAC 27G .1901 Scope (V314) for a Type A 1 rule violation and must be corrected within 23 days.