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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on March 17, 2021. The complaints were substantiated (intake #NC00174744, intake #NC00175199, intake #NC00175281). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1800 Intensive Residential Treatment for Children and Adolescents.	V 000		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS.	V 109		

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V 109	Continued From page 1 (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record reviews and interviews, one of one Qualified Professional (QP) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are: Cross Reference: G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (Tag V132). Based on record reviews and interviews, the facility failed to report the result of an investigation within 5 working days of the initial notification of the Department. Cross Reference: 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL (Tag V318). Based on record reviews and interviews the facility failed to report an allegation of abuse to the Health Care Personnel Registry (HCPR) within 24 hours of learning about the allegation. Cross Reference: 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (V367).	V 109		

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V 109	Continued From page 2 Based on record reviews and interview the facility failed to ensure a critical incident report was submitted to the Local Management Entity (LME) within 72 hours as required. Review on 03/17/21 of the QP's record revealed: -Date of hire: 05/30/19. -Job Title: QP. -The QP's job description signed on 08/06/20 "General Description The function of the Qualified Professional is to provide support and training to the habilitation, specialist, home manager, and direct care staff. The QP also services as a liaison between family members and the facility as well as other outside agencies....Duties and Responsibilities:(not limited to those listed)...3. Provide in-service training as needed...5. Initiate and complete any investigations...8. Advocate for each client...11. Review incident/accident reports 12. Report any incident/Accident to the North Carolina Incident Response Information System (NC IRIS) and to NC Health Registry if needed. 13. Provide training to Direct Care Staff regarding the overall operation of each facility." Review on 03/10/21 of the facility's internal investigation dated 02/19/21 revealed: -Accident/Incident report. "....Supervisor's Actions...Category III...State any immediate action taken (if medical emergency, include time of request for help and time of response to request) QP to [client #2] to emergency room due to him complaining about pain in left arm at 1:00pm. What actions have been taken to aid in preventing this from happening in the future? QP took [(Former Staff (FS) #15)] off shift until investigation was completed QP look at video to see what happen and let DSS (Department of Social Services) work know what happen and took [FS #14] off shift due to her no intervene."	V 109		

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V 109	Continued From page 3 -An undated statement by QP "...While at the emergency room, QP looked at the video to start the internal investigation. QP saw that the staff used an inappropriate hold that was not taught by the company. QP contacted his parent and DSS was called...QP also seen were [FS #14] was near the incident. QP question [FS #14] on 02/22/21. QP asked [FS #14] why she did not intervene? She stated he (FS #15) had it under control. QP explained to her that anytime a inappropriate hold is made, you have to intervene or let home manager now right then since home manager was on shift. Also, explained to [FS #14] the seriousness of being near incident can cause her to be in trouble for Neglect. [FS #14] understood and was in-serviced." -FS #15 was terminated on 02/26/21 and the internal investigation was substantiated. Review on 03/10/21 of the facility's internal investigation dated 03/03/21 revealed: -Accident/Incident report "...Supervisor's action...Category III...State any immediate action taken (if medical emergency, include time of request for help and time of response to request) Staff (FS #13) left premises after the incident. QP completed internal investigation and watched video to see what happen. What actions have been taken to aid in preventing this from happening in the future? Staff immediately let DSS worker know what happen and inservice staff on how to step in when you see staff getting out of control. Also, scheduled training on how to deescalate the behavior." -An undated statement by QP "...She stated it was about the situation that happen on 3/3/2021 with [client #9] and staff [FS #13] and [FS #14]. [FS#13] was in a physical fight with [client #9]. He was hitting physically hitting [client #9]. When QP completed a body check, there was some	V 109		

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V 109	Continued From page 4	V 109		

scratches on the right side, right side of his eye, and his left ear was red in color; and scratched behind his left ear. [Client #9] told QP that [FS #14] threatens him stating she got him tomorrow which was considered 3/4/2021. QP did get a phone called from the Home Manager stating the [FS #13] said he is not coming back to work with the company. QP called [FS #14] to have her come in the office, she did not pick up my phone called but picked up home manager. She was scheduled to come in the office on 3/4/2021 at 12pm. She did not show up. The team agreed to go ahead an terminate her form Carter Clinic P.A."

Interview on 03/09/21 and 03/17/21 the QP stated:
-She had watched the videos from incidents on 02/19/21 and 03/03/21.
-FS #15 use of force had not been taught in CPI (Crisis Prevention Institute - nonviolent crisis intervention).
-It had not appeared to be a need for any type of hold or restrictive intervention to be used on client #2.
-FS #13 had not used an appropriate CPI intervention.
-She had completed in-services with staff #7 and staff #8 in lieu of write ups.
-There had been a delay in reporting to Healthcare Personnel Registry for FS #15.
-She acknowledged all staff should have been trained after the 02/19/21 incident.
-Staff were trained on the same policies they had received training on previously upon hire.

Review on 03/17/21 of the Plan of Protection dated 03/17/21 and completed by the QP and Residential Director revealed:
-"What immediate action will the facility take to

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V 109	Continued From page 5 ensure the safety of the consumers in your care? QP will be re-trained on competence demonstrated by exhibiting core skills such as technical knowledge; cultural awareness; analytical skills; decision-making; interpersonal skills communication skills; and clinical skills." -"Describe your plans to make sure the above happens. QP will review and keep updates on the NC Incident Response and Reporting on Level 1,2, and 3 incidents. Home Manager will be re-Inservice on Incident Reporting. The Residential Director will re in-service QP on the competence the demonstrating the core skills. QP will schedule training immediately with staff. The Residential Director will oversee to make sure all trainings are completed and implemented as needed. CPI instructor will make staff are using the correct CPI Holding skills and how-to-de-escalating behavior. Qualified Professional and Home Manager will be in-service to go to the facility as soon as possible when incident happen." Client #2 and client #9 had diagnoses to include Disruptive Mood Dysregulation Disorder, Unspecified Anxiety Disorder Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Mild Intellectual Developmental Disability and Depressive Disorder. Their ages were 14 and 16 respectively. On 2/19/21, client #2 was harmed and abused by FS #15 resulting in a fractured arm. QP recognized FS #14 had been neglectful when she failed to intervene and report incident immediately. The QP completed an in-service training for cell phone usage and reporting inappropriate actions, abuse, neglect, harm or exploitation with FS #14. All staff had been trained to ensure staff understood client rights and client abuse, neglect, harm or exploitation or how to de-escalate clients.	V 109		

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V 109	Continued From page 6 Subsequently, on 3/3/21 client #9 was abused by FS #13 while staff #7 and staff #8 watched and stood in the hallway and did not intervene. FS #14 sat in a nearby chair as FS #15 abused client #2 and did not intervene. Staff #7, staff #8 and FS #14 actions did not protect client #2 and client #9 from harm and abuse. The QP completed in-service training with staff #7 and Staff #8. The QP's responsibilities included and was not limited to ensure staff are trained. She retrained the staff on the same procedures received at hire. Staff #7 and Staff #8 were not reported to HCPR for neglect when client #9 was abused by FS #13. FS #14 was not reported to HCPR for neglect when client #2 was abused by FS #15. Additionally, the QP failed to report to the LME/MCO and HCPR within the required time. The QP's failure to address the neglect of staff, retrain all staff, report to the HCPR and report required incidents was detrimental to the health, safety and welfare of client #2 and client #9. This deficiency constitutes a Type B rule violation. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 109		
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.	V 118		

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V 118	Continued From page 7 (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 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 record review, observation and interview, the facility failed to administer medications on the written order of a physician and failed to keep the MARs current affecting two of three audited clients (#5 and #9). The findings are: Finding #1: Review on 03/11/21 of client #5's record revealed: -16 year old male. -Admission date of 08/28/20. -Diagnoses of Attention Deficit Hyperactivity	V 118		

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V 118	Continued From page 8 Disorder (ADHD) and Conduct Disorder. Review on 03/09/21 of client #5's signed physician orders dated 02/15/21 revealed: -Vanoxide - Lotion (combination antibacterial and steroid medicine that is used to treat acne) - apply to affected every day after cleaning the skin. Review on 03/09/21 of client #5's March 2021 MAR revealed staff initials to indicate the Vanoxide - lotion was administered daily. Observation on 03/09/21 at approximately 1:00pm of client #5's medications revealed no Vanoxide - lotion available for administration. Interview on 03/09/21 client #5 stated he received all of his medications daily. Finding #2: Review on 03/10/21 of client #9's record revealed: -16 year old male. -Admission date 03/23/20. -Diagnoses of ADHD of childhood with hyperactivity; Oppositional Defiant Disorder; Intellectual Developmental Disorder Mild and Unspecified Depressive Disorder. Review on 03/09/21 of client #9's signed physician orders dated 02/15/21 revealed: -Retin-A 0.1% (percent) cream (used to treat acne) - apply to affected area at bedtime. Observation on 03/09/21 at approximately 1:00 pm of client #9's medications revealed no Retin-A 0.1% cream available for administration. Interview on 03/09/21 client #9 stated he received	V 118		

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V 118	Continued From page 9 all of his medications daily. Interview on 03/09/21 the House Manager stated: -She was not able to locate the Vanoxide - HC lotion in client #5's medications. -No Retin-A was provided for review for client #9. [This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.]	V 118		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged	V 132		

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V 132	Continued From page 10 acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report the result of an investigation within 5 working days of the initial notification of the Department. The findings are: Review on 03/10/21 of a North Carolina Incident Response Improvement System (IRIS) report for client #2 revealed: -Date of incident: 02/19/21. -Alleged physical abuse against Former Staff (FS) #15 on 02/19/21. -Date report and investigation originally submitted to Health Care Personnel Registry (HCPR) was 03/03/21. Interview on 03/17/21 the Qualified Professional stated: -She had completed an IRIS report and investigation for client #2's allegation against Former Staff #15 on 02/19/21.	V 132		

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V 132	Continued From page 11 -She understood the IRIS report documentation indicated it was submitted to the HCPR on 03/03/21. -She understood the results of all investigations must be reported to the HCPR within five working days of the initial notification to the Department. This deficiency is cross referenced into 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (V109) for a Type B and must be corrected within 45 days.	V 132		
V 304	27G .1804 Intensive Res. Tx. Child/Adol - Min staffing 10A NCAC 27G .1804 MINIMUM STAFFING REQUIREMENTS (a) A Qualified Professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) If children or adolescents are cared for in separate units/buildings, the minimum staffing numbers shall apply to each unit/building. (c) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) three direct care staff shall be present for up to six children or adolescents; (2) four direct care staff shall be present for seven, eight or nine children or adolescents; and (3) five direct care staff shall be present for 10, 11 or 12 children or adolescents. (d) During child or adolescent sleep hours three direct care staff shall be present of which two shall be awake and the third may be asleep. (e) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(d) of this	V 304		

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V 304	Continued From page 12 Rule, more direct care staff may be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to meet the minimum staffing requirements. The findings are: Observation on 03/09/21 at 10:15am of the facility revealed: -3 staff (staff #1, staff #2, House Manager) present with 12 clients at the facility. -The Qualified Professional (QP) arrived approximately 30 minutes later at the facility. Interview on 03/09/21 client #2 stated: -There had typically been 3 to 4 staff on shift. Interview on 03/09/21 client #5 stated: -There had been 4 to 5 staff on 1st shift. -There had been 3 to 4 staff on 2nd shift. -There had been 2 to 3 staff on 3rd shift. Interview on 03/09/21 staff #1 stated: -She had worked 1st shift. -There had been 4 to 5 staff during her shift. Interview on 03/09/21 staff #2 stated: -He had worked all shifts. -There had been 4 staff on shifts. Interview on 03/10/21 former staff (FS) #13 stated:	V 304		

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V 304	Continued From page 13 -He had worked 2nd shift. -There was supposed to be 5 staff on shift. -He had worked a shift with 2 staff and shift with 3 staff. -The facility had been short staff for the past month. Interview on 03/10/21 staff #8 stated: -There had been 3 to 5 staff on shift. Interview on 03/10/21 staff #4 stated: -He had worked 2nd shift. -There had been 4 staff on shift. Interview on 03/10/21 staff #7 stated: -There had been 4 to 5 staff per shift. Interview on 03/09/21 the House Manager stated: -There had been 12 clients at the facility. -There had been 3 staff at facility when surveyors arrived and 4 staff to include QP who arrived later. -There had normally been 5 staff on shift but some staff had been discharged. -Shifts were from 7-3pm, 3-11pm and 11-7am. -There had been 4 to 5 staff on shift on 02/19/21 when a client was injured by a staff. -There was supposed to be 5 staff on shift. Interview on 03/09/21 the QP stated: -The facility had been short staffed. -There was supposed to be 5 staff on shift.	V 304		
V 318	13O .0102 HCPR - 24 Hour Reporting 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care	V 318		

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V 318	Continued From page 14 personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g). This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to report an allegation of abuse to the Health Care Personnel Registry (HCPR) within 24 hours of learning about the allegation. The findings are: Finding #1: Review on 03/10/21 of a North Carolina Incident Response Improvement System (IRIS) for client #2 revealed: -Date of incident: 02/19/21. -Time of incident: 11:00am. -Alleged physical abuse against Former Staff (FS) #15 on 02/19/21. -No documentation FS #14 neglected to protect client #2 from abuse. -IRIS report originally submitted on 03/03/21. -No documentation the HCPR was notified of the allegations within 24 hours as required. Finding #2: Review on 03/10/21 of an IRIS for client #9 revealed: -Date of incident: 03/03/21.	V 318		

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V 318	Continued From page 15 -Time of incident: 5:00pm. -Allegation of verbal abuse against FS #14 and physical abuse against FS #13 on 03/03/21. -No documentation staff #7 and staff #8 neglected to protect client #9 from abuse. -IRIS report was submitted to HCPR on 03/05/21 which is greater than 24 hours from learning about the allegations. Interview on 03/17/21 the QP stated: -She had completed an IRIS report and investigation for client #2's allegation against FS #15. -She understood the IRIS report documentation indicated client #2's allegation was submitted to HCPR on 03/03/21. -She had completed an IRIS report and internal investigation for client #9's allegations against FS #13 and FS #14. -The HCPR was completed on 3/5/21. -She understood the HCPR was to be notified of all allegations of abuse within 24 hours. This deficiency is cross referenced into 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (V109) for a Type B and must be corrected within 45 days.	V 318		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients	V 367		

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V 367	Continued From page 16 to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of	V 367		

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V 367	Continued From page 17 Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.	V 367		

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V 367	Continued From page 18 This Rule is not met as evidenced by: Based on record reviews and interview the facility failed to ensure a critical incident report was submitted to the Local Management Entity (LME) within 72 hours as required. The findings are. Review on 03/10/21 of a North Carolina Incident Response Improvement System (IRIS) report for client #2 revealed: -Incident date: 02/19/21. -Time of incident: 11:00am. -Alleged physical abuse against Former Staff (FS) #15 on 02/19/21. -IRIS report submitted to the LME/MCO on 03/03/21. -IRIS report was not submitted to the LME/MCO within 72 hours as required. Interview on 03/17/21 the QP stated: -She had completed an IRIS report for client #2's allegation against FS #15 on 02/19/21. -She understood the IRIS report documentation indicated it was submitted 03/03/21 and IRIS reports must be submitted to the LME/MCO within 72 hours of learning of the incident. This deficiency is cross referenced into 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (V109) for a Type B and must be corrected within 45 days.	V 367		
V 503	27D .0103 Client Rights - Search And Seizure Policy 10A NCAC 27D .0103 SEARCH AND SEIZURE POLICY (a) Each client shall be free from unwarranted	V 503		

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V 503	Continued From page 19 invasion of privacy. (b) The governing body shall develop and implement policy that specifies the conditions under which searches of the client or his living area may occur, and if permitted, the procedures for seizure of the client's belongings, or property in the possession of the client. (c) Every search or seizure shall be documented. Documentation shall include: (1) scope of search; (2) reason for search; (3) procedures followed in the search; (4) a description of any property seized; and (5) an account of the disposition of seized property. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 audited clients (client #9) was free from unwarranted invasion of privacy. The findings are: Review on 03/10/21 of client #9's record revealed: -16 year old male. -Admission date 03/23/20. -Diagnoses of Attention Deficit Hyperactivity Disorder of childhood with hyperactivity; Oppositional Defiant Disorder; Intellectual Developmental Disorder Mild and Unspecified Depressive Disorder. Review on 03/09/21 of the facility's video surveillance revealed: -Client #9's full bedroom including his bed had been within view of video camera. Interview on 03/09/21 the house manager stated:	V 503		

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V 503	Continued From page 20 -Room 13 was occupied by client #9. Interview on 03/17/21 the Qualified Professional stated: -She had been aware the video camera showed client #9's bedroom. -No other cameras showed another client's bedroom. -The location on the back hallway camera had been the only camera which showed a client bedroom.	V 503		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.	V 512		

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V 512	Continued From page 21 This Rule is not met as evidenced by: Based on record reviews and interviews, two of three former staff (FS) (#13 and #15) abused two of three audited clients (#2 and #9) and two of six audited current staff (#7 and #8) and one of three FS (#14) failed to protect two of three audited clients (#2 and #9) from abuse. The findings are: Finding #1: Review on 03/10/21 of client #2's record revealed: -14 year old male. -Admission date of 10/21/20. -Diagnoses of Disruptive Mood Dysregulation Disorder and Anxiety Disorder. Review on 03/10/21 of FS #15's record revealed: -Date of hire: 11/21/19. -Date of separation: 02/26/21. -Abuse and Neglect training -7/20/20. -CPI (Crisis Prevention Institute - nonviolent crisis intervention) 07/24/20. Review on 03/11/21 of FS #14's record revealed: -Date of hire: 06/19/20. -Date of separation: 03/04/21. -CPI - 07/22/20. Review on 03/10/21 of a North Carolina Incident Response Improvement System (IRIS) for client #2 and originally submitted on 03/03/21 revealed: -Date of incident: 02/19/21. -Time of incident: 11:00am. -Alleged physical abuse against FS #15 on 02/19/21. -"Describe the cause of this incident, (the details of what led to this incident). Staff used an inappropriate hold such as a Therapeutic Skilled	V 512		

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Hold. Carter Clinic Residential is not trained on Therapeutic Skill hold. The staff is trained on CPI Holding skill. When staff pulled his arm back and twisted it caused the client to have a fracture in his left arm. QP (Qualified Professional) took staff off shift. QP completed a internal investigation."
-"Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. The incident could have been prevent by just taking the computer from the client when he was going on inappropriate sites on laptop. If he was combative towards staff he could have ask [Client #2] to go take 5 minutes of calm time. QP completed the internal investigation. The outcome of investigation was substantiated. Staff was taken off shift when the incident occurred. Staff will be terminated from Renewing Grace Residential Home."
-The local Department of Social Services was notified on 02/19/21.
-Facility Substantiated abuse and FS #15 was terminated on 02/26/21.

Review on 03/10/21 of a handwritten statement signed by FS #15 and dated 02/19/21 revealed:
-"After [Client #2] got his laptop took for try to go on inappropriate sites after staff had already prompt him. [Client #2] became verbal...I, [FS#15] prompt [Client #2] to got to his room several time he refused. [Client #2] became more aggressive by try to get up and assault me I [FS #15] grab [Client #2] and [illegible] [Client #2] in a therapeutic still hold [Client #2] because physical aggressive by trying to bite me [illegible word] holding [Client #2] for 20 sec. (seconds). [Client #2] said he was okay and he would stop. I [FS #15] replied okay and released [Client #2] to his room and started talking to [Client #2] to ask him

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V 512	Continued From page 23 was he okay." Review on 03/10/21 of an unsigned handwritten statement from FS #14 revealed: -Date "2-19-20." -"Written Statement: I was sitting on the couch when I witnessed [Client #2]." -No additional documentation. Review on 03/10/21 of written statements from Staff #1 and the House Manager revealed they did not witness the 02/19/21 incident between client #2 and FS #15. Review on 03/10/21 of an Emergency Room report for client #2 dated 02/19/21 revealed: -Reason for visit: Elbow injury. -Diagnosis: Broken arm. -Follow up with Orthopedic Surgeon. Review on 03/09/21 of an Orthopedic note dated 03/01/21. -Fracture was "mildly displaced." -Will repeat X-rays. -"If it continues to be displaced will require ORIF (Open Reduction Internal Fixation)." Review on 03/09/21 of the facility's video surveillance revealed: -Date: 02/19/21. -Video with no sound recording begins at 9:25:19. -Client #2 can be seen sitting in between two other clients at a table. The table is in an open room. No laptop or other items can be seen on the table in front of client #2. -FS #14 is seated on a couch approximately 10 feet from client #2. -At 9:25:45 FS #15 approached client #2 on his left side and appears to be engaged in a conversation. Client #2 can be clearly seen	V 512		

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seated at the table with his fingers extended and touching together.
-From 9:25:46 to 9:25:55 client continued to sit in his seat and made no threatening motion or sudden action towards FS #15 or other clients at his table.
-At 9:25:55 FS #15 grabbed client #2's left arm and proceeded to bend back client #2's left wrist.
-FS #15 then continues the motion to bend client #2's left wrist and extend client #2's left arm straight behind client #2's back. Client #2's face is down on the table.
-At 09:25:58 FS #15 begins to bend client #2's hand towards the left side of client #2' s neck and his arm is folded behind his back. Client #2's palm was facing away from his back. Client #2's face remained on the table.
-FS #15 continues to cinch client #2's arm in the above manner. Client #2 appeared to attempt to stand up to relieve pressure from the torque placed on his arm and shoulder.
-At 9:26:13 as client #2 appeared to struggle with his arm angle, FS #15 placed his arm in the crease of client #2's left elbow area and secured his wrist to control client #2's posture. The video showed a rocking motion from FS #15 as he attempted to keep client #2 in place and face down on the table. No evidence of client #2 attempting to bite FS #15.
-At 9:26:17 FS #15 began to release the hold on client #2's arm.
-At 9:26:22 FS #15 escorted client #2 off camera.
-FS #14 never left the couch or made an attempt to intervene verbally or physically during FS #15's abuse of client #2.

Review on 03/17/21 of an inservice training signed by FS #14 and dated 02/22/21 revealed:
-"Purpose/Outline of Training: When you witness any one doing anything inappropriate report it to

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V 512	Continued From page 25 the appropriate authorities such as home manager/QP. Make sure you report any type of abuse, neglect, harm or exploitation immediately." Interview on 03/09/21 client #2 stated: -He had his arm broken 2 or 3 weeks ago. -He would not get off his laptop. -FS #15 put his arm so far behind his back it "broke." -He went to his room and later his arm started hurting. -He was taken to a medical center for treatment. -He now has a sling and a brace. -He had an appointment with Orthopedic for follow up. Interview on 03/11/21 FS #15 stated: -He recalled the incident with client #2 on 02/19/21. -Client #2 was fussing at other clients and the female staff. -Client #2 was trying to go on "porn" sites. -Client #2 had a history of sexual issues and tried to go on inappropriate sites. -Client #2 had his computer taken away. -Client #2 can be aggressive and he seemed to be getting up. -"I was trying to secure him (client #2) and must have put on too much pressure." -He had CPI training and putting the arm behind a client's back is not an approved hold. -Client #2 was clinching his fist and I thought he was a threat. -When he had client #2's arm he felt client #2 "tensing" up and "I must have put too much weight on him." -He had kids of his own and would never want anyone to hurt them. -He had worked in the field for many years and never had anything like this happen.	V 512		

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V 512	Continued From page 26 -He was trying to keep client #2's arm on his side and it moved up. -"I feel so bad." -I wanted to know if client #2 was ok but no one from the facility had spoken with him. -"I am paying for it (injury to client #2) thinking what I could have done to prevent. Maybe him (client #2) going to his room." -He did not plan any injury or aggression toward client #2. -"I keep playing in my mind how it happened and what I could have done." Attempt to interview FS #14 on 03/11/21 was unsuccessful due to inability to reach via phone. There was no ability to leave a voice message. Finding #2 Review on 03/10/21 of client #9's record revealed: -16 year old male. -Admission date 3/23/20. -Diagnoses of Attention Deficit Hyperactivity Disorder of childhood with hyperactivity; Oppositional Defiant Disorder; Intellectual Developmental Disorder Mild and Unspecified Depressive Disorder. Review on 03/10/21 of FS #13's record revealed: -Date of hire: 06/18/20. -Date of separation: 03/03/21. -CPI - 07/24/20; Protection from harm, abuse, neglect or exploitation - 07/20/20; Client Rights - 07/21/20; Seclusion, Physical restraint an isolation time out - 07/21/20. Review on 03/11/21 of staff #7's record revealed: -Date of hire: 10/01/20. -CPI - 10/29/20; Protection for harm, abuse, neglect or exploitation -10/29/20; Incident and	V 512		

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accident reporting - 10/29/20; Client Right's -10/29/20; Seclusion, physical restraint and Isolation -10/29/20.

Review on 03/11/21 of staff #8's record revealed:
-Date of hire: 01/26/21.
-CPI - 02/04/21.

Review on 03/11/21 of handwritten statements signed by staff #4 and dated 03/03/21 revealed:
-"At approximately 5:45pm staff [FS #13] came back into facility and gave me an incident report to give to house manager [(HM)]. Staff [FS #13] was accompanied by staff [FS #14]. Staff [FS #14] entered the facility also and proceeded down the hall yelling and cursing to confront client [client #9] who was in shower. Staff [FS #14] left building after approximately 90 seconds. Staff [FS #14] was redirected by staff [FS #13]."
-"I have knowledge of incident between staff and client earlier this afternoon. I was receiving and checking in...medications in the med office. I was asked by staff [staff #7' initials] to call House Manager [HM's initials] at approximately 4:58pm and I did so."

Review on 03/11/21 of a handwritten statement signed by staff #7 and dated 03/03/21 revealed:
-"At 4:55pm client [client #9] was yelling down the hall At staff ([FS #13]) cussing and calling staff the (N) word and hope his family die so he could piss on there grave that's when ([FS #13]) told client [client #9] to go in his room and ([client #9]) stated that he wont going no where and staff told ([client #9]) to go in his room Again and ([client #9]) then steped in Another client Room ([client #3] and [client #4]) that staff walked down there with client and Asked him to go in his room again and that's when ([Client #9]) swung on staff ([FS #13]) and [FS #13] and client begun to Fight and

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V 512	Continued From page 28 then the staff held client until he calm down." Review on 03/11/21 of a handwritten statement signed by staff #8 and dated 03/03/21 revealed: -"Upon coming off break and entering the facility staff 1 heard consumer [client #9] yelling at staff ([FS #13]) calling him n****r and telling him he wanted to piss on his grandmothers grave, staff 1 then entered the kitchen and got a pear and as he walked on he continued to hear consumer [client #9] yelling obsenities at staff ([FS#13]), staff 1 then tried to redirect consumer [client #9] and tried to convince him to go to his room, consumer [client #9] ignored staff 1 and continued to be verbally aggressive, staff ([FS #13]) again told him to go into his room and calm down, consumer [client #9] then ran into another consumers room staff ([FS #13]) and consumer [client #9] began to tussle until staff ([FS #13]) could get him against the wall, staff 1 then attempted to keep the other consumers calm and had them go into their rooms." Review on 03/9/21 and 03/12/21 of the facility's video which contained no sound recording revealed: -Location of camera: Back Hall. -Date: 03/03/21. -Time: 16:59 - 17:10 (4:59pm - 5:10pm) -Client #9 stood at the end of the hallway with his body facing the opposite end of the hallway. His back faced the camera. -FS #13 sat in a chair on the opposite end of the hall/next to common sitting area from client #9. -Client #6 stood in the door of his bedroom. He had also faced the opposite end of the hall. -From 4:59:56 to 5:01:17 client #9 and FS #13 appeared to be in a verbal exchange. -From 5:01:17 to 5:01:48 Client #9 went across the hallway into another client's bedroom and FS	V 512		

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#13 stood up and spoke towards client #9. Client #9 verbally responded back. Client #9 stood in the doorway of another client's bedroom then went back into the hall.
-At 5:01:48 FS #13 left his chair and walked towards client #9.
-From 5:01:56 to 5:02:01 FS #13 grabbed client #9's right wrist and client #9 grabbed FS #13's left forearm. FS #13 held client #9 and they struggled for a few seconds both appeared to pull away from the other. Client #9's back was against the hall. FS #13 stood in front of client #9 appeared to slightly lean forward with his hand in front of him.
-At 5:02:04 Client #9 hit FS #13 on the left shoulder. FS #13 hit client #9 with a closed fist in a punching motion approximately 5 times in his face and upper body.
-From 5:02:16 to 05:03:27 Client #9 and FS #13 interlocked arms. Staff #7 seemed to notice the interaction between client #9 and FS #13 and casually walked down the hall with his hands behind his back. Staff #8 shortly followed behind staff #7 while he ate a piece of fruit. FS #13 grabbed client #9's tshirt and ripped the T-shirt off of client #9's body and threw it to the floor while client #9 is leaned forward. FS #13 appeared to place client #9 in a headlock. Client #9's upper back and shoulders became red. Staff #7 stood against the door of the next bedroom. Staff #8 stood further down the hall. Both observed the physical interaction between client #9 and FS #13 and at no time did either staff #8 or staff #7 attempt to intervene to protect client #9. Client #9 was able to pull his head from under FS #13 arm and release himself from the headlock. FS#13 arms continued to be wrapped around client #9. FS #13 continued to hold client #9 against the wall and both staff #7 and staff #8 turned and walked away in the opposite direction away from

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V 512	Continued From page 30 client #9. -At 5:03:27 FS #13 turned and by pushing and pulling to force client #9 into his room. Client #9 appeared to resist. FS #13 grabbed client #9 about his body, pushed client #9 then the pair went off camera into another corner from approximately 30 seconds. Staff #8 walked towards the pair again and stood a few feet away. -From 5:04:10 to 5:04:25 FS #13 and client #9 returned to camera view and FS #13's arms were wrapped under client #9's arms. Client #9 attempted to get away from FS #13. FS #13 continued to hold client #9 under his arms and pulled client #9 towards his room and then physically pushed/pulled client #9 into his bedroom. -From 5:04:25 to 5:04:47 FS #13 threw client #9 on the bed face down and held client #9 with his arm about his neck/head. FS #13 straddled client #9's back while holding his head down. Client #9's knees were on the floor and his upper body on the bed. Client #9 was struck by FS #13 on his side several times. FS #13 then placed his forearm and elbow into client #9's neck. Staff #7 picked up client #9's shirt off the floor and threw it into client #9's bedroom and closed the door leaving FS #13 and client #9 in the room alone while FS #13 was straddling the back of client #9.. Staff #7 and staff #8 continued back down the hall towards common area. -At 5:05:42 FS #13 and client #9 had been in client #9's bedroom for approximately 50 seconds before FS #13 walked out. -In his bedroom, client #9's face had not been in camera view however he appeared to wipe his face and looked at his hand. Client #9 physically examined himself and appeared to look for injuries then sat on his bed. -FS #13 walked down the hall and staff #8 followed behind him. Client #9 was left	V 512		

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V 512	Continued From page 31 unattended in his room for approximately 1 minute and 50 seconds. -At 5:07:18 Staff #4 had been on the phone when he approached staff #7 and #8 and they walked towards client #9's bedroom. Client #9 had stood up and glanced out the door as staff approached. Client #9 appeared upset and showed the staff injuries sustained. Staff #4 walked into hall while on the phone then returned to client #9's room and client #9 appeared to speak towards the phone. -At 5:08:39 FS #13 returned to client #9's room and was immediately redirected by staff #4. Staff #4 went into client #9's room and closed the door while staff #8 stood outside the room next to the door. -The video ended at 17:10 (5:10pm). Review on 03/11/21 of 3 in-service trainings signed by staff #7 and staff #8 completed on 3/4/21 revealed: -"Title of Training: Seclusion, Physical Restraints and Isolation...Purpose/Outline of Training: Make sure you use only CPI skills when situation happens also make sure you intervene in situation before it get out of control and de-escalate situation as train in CPI Holding Skill Class." -"Title of Training: Client Rights, How to deal w/ (With) Crisis and How to deescalate crisis...Purpose/Outline of Training: See attached sheet" The facility's policy had been attached. -"Title of Training: Abuse, Neglect, Harm and Exploitation and Examples of all...Purpose/Outline of Training: See attached sheet." Facility's policy attached. -QP completed trainings. -Staff #7 completed the same trainings on 10/29/20 at hire.	V 512		

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V 512	Continued From page 32 -Staff #8 was hired on 1/26/21 and trained on 2/4/21. Review on 03/11/21 of 2 In-Service Training forms signed by 9 of 12 staff on 3/4/21 revealed: -"Title of Training: Reporting any incident or abuse Immediately...Purpose/Outline of Training: If you see a client being abuse immediately remove client from situation call QP number is poster in office Also in med Room or any incident that occur while providing services." -"Title of Training: Intervene before situation get out of control...Purpose/Outline of Training: If you see a staff getting out of control intervene immediately call manager and QP number are poster in office also in med room." Interview on 03/09/21 client #9 stated: -He had been in his room and staff would not let him make a phone call. -FS #13 had confronted him about telling HM he had not made a phone call. -FS #13 told him to step into the hall. -He had admittedly called FS #13 an inappropriate word. -He had lightly hit FS #13 and FS #13 hit him hard. -FS #13 had placed him in a "choke hold position and had yanked his neck up." -FS #13 had put him in his bedroom and put him on the bed then had hit him in his head, face and ribs. -FS #13 told him to apologize and he did. When he had apologized when FS #13 hit him for the apology. -Staff #7 and staff #8 had stood in hallway "like nothing had happened." -He had a bruise on his side and a scratch on his temple area. -The HM had called and he told her what	V 512		

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happened with FS #13.
-FS #13 overheard him and told him to stop lying.
-He had been in the shower when FS #14 had came to the facility about the incident with FS #13.
-His peers had told him FS #14 had came to the facility and was screaming and yelling.

Interview on 03/09/21 client #2 stated:
-FS #13 had fought client #9.
-Client #9 had threw the first punch.
-FS #13 told client #9 to go to his room and client #9 said no and went into the hall.
-FS #13 had threatened to take client #9's phone call.
-Client #9 called FS #13 the "N word" and FS #13 responded and said call him that one more time.
-Client #9 and FS #13 started "throwing punches".
-Client #9 had a scratch on his eye. Client #9 told him about a bruise on his side.

Interview on 03/09/21 client #5 stated:
-Client #9 had hit FS #13 and FS #13 hit him back.
-FS #13 had caught himself then put client #9 in a restraint.

Interview on 03/10/21 FS #13 stated:
-He had been employed at facility about a year.
-He had been trained in CPI.
-There had not been any additional trainings since he had been hired.
-Client #9 had told HM had not been allowed to make a phone call.
-He had asked client #9 about making calls.
-Client #9 had stood in the hallway about 30 minutes "talking aggressive" towards him.
-He had called the HM twice to inform her of client #9's behaviors and requested to send him

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V 512	Continued From page 34 to his room. -The HM told him "do not touch [client #9] and let him say what he wanted to say." -Client #9 had went into a peer's bedroom and he had redirected him. -He had asked client #9 to go to his room. -Client #9 told him he had been "waiting to whoop his a**." -Client #9 had punched him and attempted to punch him again. -He admitted he swung and hit client #9 and they had a "little tussle or scuffle" then he held client #9 against the wall. -He had pushed client #9 into the room and he and client #9 "tussled on the bed." -He got client #9 to calm down. -Another staff, he had not known which staff, closed the bedroom door. -He left the bedroom. -The other staff present had not intervened. -He grabbed an incident report and told the staff he was going on break and would return. -He had been told to leave. -He had been aware of client diagnoses and understood his mental capacity. Interview on 03/10/21 staff #7 stated: -He had been employed about 5 months. -He had been trained in CPI. -Client #9 and FS #13 had been arguing and he called the HM and told her. -FS #13 told client #9 to hit him and he called the HM again and the HM said take client #9 to his room. FS #13 took client #9 to his room. -He had observed FS #13 and client #9 "tussling" but FS #13 had tried to get client #9 in his room. -He had not assisted FS #13 with client #9. -FS #13 and client #9 went into the room and staff #7 closed the door so the other client would not run to see what was going on.	V 512		

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V 512	Continued From page 35 -Another staff spoke with the HM and he went to kitchen to prepare meals. -He had been in-serviced on Abuse, Neglect, Harm and Exploitation and Client Rights after incident with client #9. Interview on 3/10/21 staff #4 stated: -He had been on break during the altercation between client #9 and FS #13. -When he had returned from break, he had been in the medication room. -Staff #7 asked him to call the HM and told him a client had been struck by a staff. -The HM had asked him to walk down the hall and see what had happened. -Client #9 had been upset and said FS #13 had hit him. -He had checked client #9 for injuries and observed a reddish area on his stomach/ribcage but no broken skin. -Client #9 had not required medical attention. -He had been in-serviced to report client abuse. Interview on 03/10/21 staff #8 stated: -He had been employed about 1 month. -He had been trained in CPI. -He had heard the conversation between client #9 and FS #13 and had not initially been alarmed. -He had heard yelling between client #9 and FS #13 and had been confused because everyone had just came inside from playing basketball. -He had followed FS #13 down the hallway but FS #13 and client #9 had already "locked arms" with each other. -The other clients were aroused and he tried to calm the other clients. -FS #13 went into the bedroom with client #9 and staff #7 had closed the bedroom door. -Staff #4 had come in from break and he followed him.	V 512		

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-He had not intervened because he was in shock and he had not been sure of the facility's protocol because he had never worked in a facility.
-Staff #4 told him to stay at the bedroom door of client #9 while staff #4 called the House Manager.
-He had observed a red mark on client #9's side near his ribcage.
-He had been in-serviced on reporting client abuse.

Interview on 3/9/21 the HM stated:
-There had been a level II incident report that involved client #9 with allegations against FS #13.
-She had received a call about client #9 "acting out".
-She had told staff #7 to let client #9 remain in the hallway and let client #9 talk himself out.
-After the incident with client #9, staff had been in-serviced on "immediately stepping in if a client is being abused, reporting abuse" and a house meeting had been scheduled.
-She had written out the in-service, talked with staff and had the staff sign it.
-Staff had not been re-trained on restrictive interventions.

Interview on 3/9/21 and 3/17/21 the QP stated:
-There had been an in-serviced training for "assisting staff" with FS #14.
-She had been in the process of setting up a de-escalation training. She needed to set a date.
-Client #9 had not received medical care or been assessed by the nurse.
-Client #9 had been monitored by staff and QP.
- FS #15's treatment of client #2 was substantiated for abuse.
- FS #15 was terminated effective 02/26/21.
- The facility utilized CPI.
- FS #15 did not hold client #2's arm correctly and was not approved though CPI.

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V 512	Continued From page 37 - She had addressed reporting abuse during in-service training with FS #14 on 02/22/21 and staff #7 and staff #8 after the incident with FS #13 and client #9. - The entire facility staff had not been re-inserviced on abuse and neglect or CPI. - CPI training was scheduled for the facility. - A total of three staff had been terminated for the incidents (FS #13, FS #14 and FS #15). Review on 3/17/21 of the Plan of Protection dated 3/17/21 and completed by QP and Residential Director revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? Qualified Professional will make sure all staff involved in incident be taken off shift immediately until investigation is completed. QP will begin the internal investigation by interviewing the involved consumer and completing a full body check. QP will report any type of abuse, neglect, harm or exploitation to appropriate authorities such as NC Department of Social Services, NC Health Registry, Police, Guardian and Registered Nurse. QP will immediately instruct Facility Manager to take involved consumer to emergency room to be evaluated for any injuries. QP will submit report to NC IRIS and NC Health Registry within the same day. QP will interview the person that was involved in the incident and other staff that was on shift during the incident. Also, interview the other consumers. If any violation has been found of harm, abuse, neglect and exploitation or any type of unnecessary force on consumer that has not been taught by CPI Instructor will cause grounds for dismissal of the employee." -"Describe your plans to make sure the above happens. Qualified Professional and Home Manager will go to the facility as soon as possible when incident happen. QP will have a designated	V 512		

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	MHL078-325	A. BUILDING: _____ B. WING _____	R 03/17/2021

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RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(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 512	Continued From page 38	V 512		

room to start internal investigation. QP will instruct other staff that was not involved in the incident to remove consumer from the situation and stay with consumer until appropriate authorities get to the facility. The Residential Director will oversee to make sure all trainings are completed and implemented as needed. CPI instructor will make sure staff are using correct holding skills and how to de-escalating behaviors."

Client #2 and client #9 had diagnoses to include Disruptive Mood Dysregulation Disorder, Unspecified Anxiety Disorder, Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Mild Intellectual Developmental Disability and Depressive Disorder. Their ages were 14 and 16 respectively. On 02/19/21 a video recording showed client #2 as he sat in the classroom and was approached by FS #15. Without any visual evidence of aggression from FS #15, he placed client #2's left arm behind client #2's back with the palm of his hand facing out. The back of client #2's hand was in his neck area at the top of his (client #2's) back. For approximately 22 seconds FS #15 continued to twist and force client #2's left arm towards the neck area. When medical attention was obtained, client #2 was diagnosed with a fractured arm. Additionally, FS #14 witnessed the abusive behavior and failed to intervene to protect client #2. Client #2 reported he had refused to give up his laptop and therefore FS #15 put his arm behind him and this broke his arm. FS #15 was terminated and FS #14 was retrained on the policy she had already received training on at/during hire on 07/21/20. On 03/03/21 a video showed FS #13 approached client #9 in the hallway and began to physically throw multiple punches striking client #9. FS #13 threw client #9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 03/17/2021

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V 512	Continued From page 39 on his bed face down and FS #13 straddled client #9 across and over his back while throwing punches to client #9's right rib area. Staff #7 and staff #8 witnessed the abuse of client #9 and neglected to protect client #9 from the abuse of FS #13. Staff #7 walked to client #9's bedroom while FS #13 was on top of client #9 and closed the door and walked away and did not intervene. FS #14 arrived at the facility later that day and made verbal threats to client #9. The actions by FS #13 and FS#15 resulted in harm and abuse of client #2 and client #9. The inaction of staff #7, staff #8 and FS #14 was neglectful in failing to protect client #2 and client #9 from and abuse. These multiple staff failures of the above-mentioned areas constitutes a Type A1 rule violation for actual serious harm, abuse and neglect and must be corrected within 23 days. An administrative penalty in the amount of $3,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 512		