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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 6/4/21. The complaint was unsubstantiated (intake # NC00176660). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or 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. (f) The governing body for each facility shall develop and implement policies and procedures	V 109		

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V 109	Continued From page 1 for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record reviews, interviews and observations, 1 of 3 Qualified Professionals (QP) (the Licensed Professional (LP)) failed to demonstrate knowledge and skills required by the population served. The findings are: The following are examples of how the LP failed to demonstrate knowledge and skills: -Treatment Plans completed by the LP for 3 out of 3 clients failed to include documentation of why bedroom doors and window coverings for clients had been removed and strategies that prevented additional incidents of clients assaulting each other while being transported; -The LP failed to ensure fire and disaster drills were conducted and documented quarterly on each shift; -The LP failed to ensure medication orders were available for 1 of 3 clients and medications were administered as ordered with MARs documented for 3 of 3 clients. Interviews on 5/21/21 with the QP and the Owner revealed: -The QP had been out on medical leave and reduced duties for approximately 4 months;	V 109		

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V 109	Continued From page 2 -During the 4 months, it was the responsibility of the LP to complete her job duties. Refer to V112, V114, V118 and V742 for details. This deficiency is cross referenced into 10A NCAC 27G .1700 SCOPE (V293) for a Type B rule violation and must be corrected within 45 days.	V 109		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (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	V 110		

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V 110	Continued From page 3 for the initiation of the individualized supervision plan upon hiring each paraprofessional.	V 110		

This Rule is not met as evidenced by:
Based on record review, interviews and observations, Paraprofessionals failed to demonstrate competency in decision making skills for 2 of 6 audited staff (#3 and #6). The findings are:

Finding 1: This is an example of how staff #3 failed to demonstrate competency.

Review on 4/28/21 of client #1's record revealed:
-An admission date of 3/19/21;
-An age of 11 years old;
-Diagnoses included Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder and Major Depressive Disorder;
-Admission Assessment dated 3/19/21 included, "Reason for referral: defiant behaviors at home;"
-Comprehensive Clinical Assessment dated 4/8/21 included, "presented with the recommendation to step up from her home setting due to not following rules, difficulty respecting boundaries and smearing food on furniture;"
-Comprehensive Clinical Assessment dated 2/17/21 included, "does not comply within the home or at school, nor does she mind anyone else, and client engages in verbal and physical aggression."

Interview on 4/30/21 with client #1 revealed:

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V 110	Continued From page 4 -She had been in the bathroom taking a break from everyone and wasn't sure how long she had been in there; -Staff #3 instructed her to open the door and she had informed her that she would when she was ready; -Staff #3 "kicked it (bathroom door) down;" -"That pissed me off;" -The staff had not warned her that she was going to kick the door down; -The incident happened 1-3 weeks ago. Interview on 5/12/21 with client #2 revealed: -"[Client #1] locked herself in the bathroom and 1 of the staff (#3) had to kick the door down;" -Client #1 was in the bathroom slamming the cabinet doors and yelling curses; -The other staff tried to get her to open the door while staff #3 was in the lower part of the facility; -When staff #3 arrived upstairs and realized client #1 had locked herself in the bathroom "she kicked it real hard;" -The staff had not informed client #1 that she was going to kick the door or warn her to back up; -She was not sure of how long ago the incident had occurred or how long client #1 had been in the bathroom. Observations on 4/28/21 from approximately 11:00am - 11:30am revealed: -The hall bathroom had a handwritten sign hanging on the door, "If you have to use bathroom go to the other restroom;" -The door of the hall bathroom had a green cloth through the door handle hole and the door around the door handle hole was cracked and partially missing. Interview on 5/10/21 with staff #2 revealed: -She had been working when the hallway	V 110		

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V 110	Continued From page 5	V 110		

bathroom door had to be kicked in;
-The hallway bathroom door had gotten stuck and staff were unable to open the door;
-"The other staff member (staff #3) had to kick it in;"
-She wasn't aware that there was a client in the bathroom when the door was kicked in.

Interview on 5/11/21 with staff #3 revealed:
-The hallway bathroom was out of order because client #1 "...went in there and tore it (toilet) up;"
-"I didn't see her physically do it, but she was the last one to use the bathroom;"
-Client #1 had previously locked herself in the hallway bathroom and staff had to unlock it;
-She was not aware the bathroom door had gotten kicked and was not working when it happened..."I have no idea."

Interview on 5/14/21 with staff #4 revealed:
-The hallway bathroom was out of order because the toilet wasn't working;
-She had been informed that client #1 had locked herself in the bathroom early one morning and the staff had to kick the door in order to get her out;
-She was not sure of who was working, who had informed her or how long ago it had happened.

Interview on 5/21/21 with the Associate Professional (AP) revealed:
-She had been informed by the House Manager (HM) that one of the residents had locked herself in the hallway bathroom and staff #3 had to kick the door;
-The AP had not been informed which resident was locked in the bathroom.

Interview on 5/21/21 with the Qualified Professional (QP) revealed:

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V 110	Continued From page 6 -"It (hallway bathroom door) used to get jammed and the only time it would get jammed was when a staff was in there;" -She read a report where one of the clients locked herself in the bathroom and a staff had to kick the door down; -The QP was unable to remember which client and staff were involved or to locate the report. Interview on 4/30/21 with the Licensed Professional (LP) revealed: -She was aware that a maintenance request had been submitted for the hallway bathroom door to be fixed; -The LP was not aware of what happened to the door or how long the door had been broken; -"I couldn't tell you." Interview on 5/21/21 with the Owner revealed: -He wasn't aware that the hallway bathroom door had been kicked by staff in order to get a client out; -The Owner was surprised that staff #3 was involved and that she hadn't admitted to kicking the door. Finding 2: This is an example of how staff #6 failed to demonstrate competency. Observation on 4/28/21 from approximately 11:00am - 11:30am revealed a gold door handle on the door of the double bedroom that locked from the outside of the bedroom. Interview on 5/14/21 with staff #6 revealed: -She had rotated the door handle on the double bedroom door to prevent the clients from locking themselves in their bedroom; -She had not asked for permission or informed anyone that she had rotated the door handle;	V 110		

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V 110	Continued From page 7 -She didn't understand why rotating the door handle, so the bedroom locked from the outside was a problem. Interview on 5/21/21 with the AP revealed: -The HM had informed her that staff #6 had turned the handle on the door of the double bedroom so that it locked from the outside; -"She just turned it around to keep them (clients) from locking themselves inside the room;" -She was not aware that turning the handle so that the bedroom door locked from the outside was an issue. Interviews on 5/21/21 with the Owner and the QP revealed they were not aware that staff #6 had turned the handle on the door of the double bedroom so that it locked from the outside. This deficiency is cross referenced into 10A NCAC 27G .1701 SCOPE (V293) for a Type B rule violation and must be corrected within 45 days.	V 110		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;	V 112		

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V 112	Continued From page 8 (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement strategies to address the needs for 1 of 3 clients (#3). The findings are: Review on 4/28/21 of client #2's record revealed: -An admission date of 10/30/20; -An age of 9 years old; -Diagnoses included Adjustment Disorder and Oppositional Defiant Disorder (ODD); -Documentation dated 4/11/21 from the local hospital that included, "diagnosed with contusion of the face...was given an x-ray of nasal bones." Interview on 5/12/21 with client #2 revealed: -She had to be evaluated at the local hospital because the staff were unable to get her nose to stop bleeding; -The clients were being transported to a local	V 112		

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V 112	Continued From page 9	V 112		

park by 2 facility staff;
-The staff were sitting in the front, client #1 was sitting in the middle seat and she was sitting in the back seat with client #3;
-She had been singing and client #3 had asked her to stop;
-When she refused to stop singing, client #3 started hitting her in the face;
-"I screamed and started crying;"
-"They (the staff) looked back and then they saw my nose bleeding...they stopped (the van)."

Review on 4/28/21 of client #3's record revealed:
-An admission date of 2/10/20;
-An age of 11 years old;
-Diagnoses included Autism, PTSD, ADHD, and ODD;
-A Treatment Plan dated 3/21/21 that included no documentation that explained why client #3 had no window coverings and no documentation of strategies to prevent the client from assaulting other clients while being transported by staff.

Attempted interview and observation at approximately 5:00pm on 4/30/21 with client #3 was not successful as the client stomped her feet and balled her hands into fists and refused to answer questions.

Interview on 5/14/21 with staff #4 revealed:
-She had been employed at the facility since December 2020;
-She had been working when client #3 assaulted client #2 while being transported in the facility van;
-Clients #2 and #3 were sitting in the back seat of the van and client #2 was singing;
-"[Client #3] has a trigger that she doesn't like other people singing usually because she hears it at another pitch;"

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V 112	Continued From page 10 -"We see [client #3] just hit her (client #2) in the face over and over and over;" -She had notified the Licensed Professional of the incident. Interview on 5/14/21 with staff #5 revealed: -She had been employed since February 2021; -She had been working when client #3 assaulted client #2 while being transported in the van; -Clients #2 and #3 were sitting in the back seat of the van and client #2 was singing; -Client #3 asked client #2 to quit singing and client #2 informed client #3 that she had a right to sing; -"She (client #3) just went off the deep end;" -The van was stopped as soon as the staff heard the altercation but client #3 had already hit client #2 several times. Interview on 5/21/21 with the Associate Professional revealed the Licensed Professional was responsible for completing and updating Treatment Plans. Interview on 4/30/21 with the Licensed Professional revealed: -She was responsible for completing and updating Treatment Plans; -The LP thought the treatment plans for all clients were appropriate and up to date. This deficiency is cross referenced into 10A NCAC 27G .1701 SCOPE (V293) for a Type B rule violation and must be corrected within 45 days.	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS	V 114		

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V 114	Continued From page 11 AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure fire and disaster drills were conducted on each shift and repeated quarterly. The findings are: Interview on 4/28/21 with staff #1 revealed: -There was a total of 4 shifts that included 2 during the week and 2 during the weekends; -The 2-week shifts consisted of 3:00pm - 11:00pm and 11:00pm - 7:00am; -An additional week shift of 7:00am - 3:00pm was added during the summer months; -The 2-weekend shifts consisted of 7:00am - 7:00pm and 7:00pm - 7:00am; -She had worked at the facility for 3-4 months; -Staff #1 had participated in 1 fire drill and no disaster drills. Review on 4/28/21 of the fire drill logs revealed: -For the quarter of April 2020 - June 2020, there had been 2 drills completed during the week and	V 114		

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V 114	Continued From page 12	V 114		

none on the weekends;
-For the quarter of July 2020 - September 2020, there had been 2 drills completed during the weekend and none during the week;
-For the quarter of October 2020 - December 2020, there had been only 1 drill completed;
-For the quarter of January 2021 - March 2021, there had been 2 drills completed during the week and none on the weekends.

Review on 4/28/21 of the disaster drill logs revealed:
-For the quarter of April 2020 - June 2020, there had been only 1 drill completed;
-For the quarter of July 2020 - September 2020, there had been no drills completed;
-For the quarter of October 2021 - December 2020, there had been only 1 drill completed;
-For the quarter of January 2021 - March 2021, there had been no drills completed.

Interview on 5/10/21 with staff #2 revealed:
-She had worked at the facility for 2 years;
-"Usually, well, I haven't been there for 1 (fire drill) lately;"
-Staff #2 was unable to remember the last fire drill she participated in but thought it had been a couple of months;
-She had never participated in a disaster drill.

Interview on 5/11/21 with staff #3 revealed:
-"They're (fire and disaster drills) completed I know once a month on every shift;"
-She had participated in a fire drill in April 2021;
-Staff #3 was unable to remember the last disaster drill she participated in.

Interview on 5/14/21 with staff #4 revealed:
-She had been employed at the facility for 5 months;

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V 114	Continued From page 13 -Staff #4 had participated in a fire drill every month; -She had participated in 2 disaster drills. Interview on 5/14/21 with staff #5 revealed: -She had been employed at the facility for 3 months; -Staff #5 had participated in 2 fire drills; -She had not participated in any disaster drills. Interview on 5/14/21 with staff #6 revealed: -She had been employed at the facility since October 2019; -She had participated in 3 fire drills and 1 disaster drill since she was employed. Interview on 5/21/21 with the Associate Professional (AP) revealed: -The AP had worked at the facility for 2 years as a direct care worker; -She had started in her new position as AP yesterday (5/20/21); -The AP had been informed that fire and disaster drills were required to be completed monthly; -She wasn't aware the drills had to be completed on each shift; -It was going to be one of her responsibilities to ensure that fire and disaster drills were completed as required. Interview on 5/21/21 with the Qualified Professional (QP) revealed: -She had been employed as the QP since June 2020; -The QP had just returned from medical leave; -Previous to her employment, fire and disaster drills were not being completed routinely; -She wasn't aware that fire and disaster drills were required to be completed on each shift; -The QP thought that the drills just had to be	V 114		

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V 114	Continued From page 14 completed monthly; -It had been the responsibility of the House Manager to coordinate fire and disaster drills; -It was her responsibility to ensure that the drills were completed; -During her medical leave, it was the responsibility of the Licensed Professional (LP) to ensure drills were completed. Interview on 4/30/21 with the LP revealed: -It was the responsibility of the QP to ensure drills were being completed; -The QP had been out of work on medical leave so, "it would be me while she's away;" -"I know we do 1 drill each shift every month;" -She was not aware that the documentation for the fire and disaster drills was not available and was unable to provide documentation. Interview on 5/21/21 with the Owner revealed: -He wasn't aware that fire and disaster drills weren't being completed as required; -The Owner wasn't aware that drills had to be completed on the weekend shifts. This deficiency is cross referenced into 10A NCAC 27G .1701 SCOPE (V293) for a Type B rule violation and must be corrected within 45 days.	V 114		
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.	V 118		

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V 118	Continued From page 15 (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the 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 reviews and interviews the facility failed to administer medications as ordered by a physician and failed to keep MARs current affecting three of three clients (#1, #2 and #3). The findings are: Review on 4/28/21 of client #1's record revealed: -An admission date of 3/19/21; -An age of 11 years old;	V 118		

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V 118	Continued From page 16 -Diagnoses included Post Traumatic Stress Disorder (PTSD), Attention Deficit Hyperactivity Disorder (ADHD), and Major Depressive Disorder. Review on 4/28/21 of client #2's record revealed: -An admission date of 10/30/20; -An age of 9 years old; -Diagnoses included Adjustment Disorder and Oppositional Defiant Disorder (ODD). Review on 4/28/21 of client #3's record revealed: -An admission date of 2/10/20; -An age of 11 years old; -Diagnoses included Autism, PTSD, ADHD, and ODD. The following are examples of how the facility failed to administer medications as ordered and failed to keep MARs current: Finding 1: The facility failed to have orders for 2 medications that had been administered to client #1. Review on 4/30/21 of client #1's MAR for the month of March 2021 revealed: -Melatonin (used for sleep) 10 milligrams (mg) as needed (prn) in the pm was administered 12 out of 13 evenings; -Ester-C (used to improve immunity) prn in the am was administered 9 out of 12 mornings. Review on 4/30/21 of client #1's MAR for the month of April 2021 revealed: -Melatonin 10 mg prn in the pm was administered 28 out of 29 evenings; -Ester-C prn in the am was administered 25 out of 30 mornings.	V 118		

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V 118	Continued From page 17 Review on 4/30/21 of client #1's record revealed no documentation of orders for Melatonin or Ester-C. Finding 2: The facility failed to administer 5 medications as ordered and maintain current MARs for the months of March 2021 - April 2021 for client #1. Review on 4/30/21 of client #1's record revealed: -An order dated 2/17/21 for Risperidone (antipsychotic) 1mg, take 1 tablet by mouth in the am and pm; -Medication Error Reports dated 4/10/21, 4/13/21 (2), 4/14/21 (2), 4/15/21, 4/16/21, 4/17/21 (2) and 4/25/21 completed by facility staff indicated Risperidone was not administered because it was not available; -An order dated 4/11/21 for Clonidine Hydrochloride (HCL) (sedative) .1 mg, take 1 tablet at noon and 2 tablets at bedtime; -An order dated 4/11/21 for Atomoxetine HCL (used to treat ADHD) 40 mg, take 1 capsule by mouth daily; -Medication Error Reports dated 3/28/21, 4/3/21, 4/5/21, 4/13/21, and 4/14/21 completed by facility staff indicated Atomoxetine Hydrochloride was not administered because there was none available; -An order dated 4/11/21 for Desmopressin Acetate (used to prevent bed wetting) .2 mg, take 3 tablets by mouth at bedtime; -An order dated 4/11/21 for Cetirizine HCL (used to treat allergies) 10 mg, take 1 tablet my mouth at bedtime. Review on 4/30/21 of client #1's MAR for the month of March 2021 revealed: -Risperidone 1 mg, take 1 tablet by mouth in the pm was blank from 3/27/21 - 3/31/21;	V 118		

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V 118	Continued From page 18 -Clonidine HCL, take 2 tablets at bedtime was blank on 3/25/21; -There was no documentation as to why client wasn't administered 5 doses of Risperidone and 1 dose of Clonidine HCL; -Atomoxetine HCL 40 mg, take 1 capsule by mouth daily had circled initials from 3/27/21 - 3/31/21 indicating the medication had not been administered; -There was documentation on the back of the MAR on 3/29/21 that indicated Atomoxetine HCL wasn't administered because there was none available. Review on 4/30/21 of client #1's MAR for the month of April 2021 revealed: -Risperidone 1 mg, take 1 tablet by mouth in the am had circled initials indicating it had not been administered from the 11th - 18th; -There was no documentation as to why Risperidone wasn't administered for 6 of 8 doses; -"0 left in bottle;" was documented on the back of the MAR for 2 of the 8 doses of Risperidone that was not administered; -Risperidone 1 mg, take 1 tablet by mouth in the pm had 1 circle with no initials, 5 circled initials and 1 blank from the 10th - 17th and blanks on the 19th and the 23rd for a total of 9 doses; -There was no documentation as to why 9 doses of Risperidone weren't administered; -Clonidine HCL .1 mg, take 1 tablet at noon had 4 blanks; -Clonidine HCL .1 mg, take 2 tablets at bedtime had 3 blanks; -There was no documentation as to why Clonidine HCL wasn't administered for 7 doses; -Atomoxetine HCL 40 mg, take 1 capsule by mouth daily had 8 circled initials (4/2/21 - 4/7/21 and 4/13/21 - 4/14/21) indicating medication wasn't administered;	V 118		

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V 118	Continued From page 19 -Documentation on the back of the MAR on 4/2/21 - 4/3/21 and 4/5/21 indicated Atomoxetine HCL was not administered because there was none available; -Desmopressin Acetate .2 mg, take 3 tablets by mouth at bedtime had 1 blank on 4/23/21; -Cetirizine HCL 10 mg, take 1 tablet by mouth at bedtime had 1 blank on 4/23/21; -There was no documentation as to why Desmopressin Acetate and Cetirizine HCL weren't administered. Finding 3: The facility failed to administer 6 medications as ordered and maintain current MARs for client #2 for the months of February 2021 - April 2021. Review on 4/30/21 of client #2's record revealed: -An order dated 4/8/21 for Amphetamine-Dextroamphetamine (stimulant) 20 mg, take 1 tablet by mouth in the am; -Medication Error Reports dated 2/1/21, 4/4/21 - 4/8/21, 4/10/21, 4/13/21-4/14/21, and 4/16/21 completed by facility staff indicated Amphetamine-Dextroamphetamine was not administered because there was none available; -An order dated 4/18/21 for Cetirizine HCL 1 mg/milliliter (ml), take 1 teaspoon by mouth every day at bedtime; -Medication Error Reports dated 3/13/21 and 4/20/21 - 4/21/21 completed by facility staff indicated Cetirizine HCL wasn't administered because there was none available; -An order dated 3/3/21 for Trazodone (antidepressant) 50 mg, take 1 tablet by mouth at bedtime; -An order dated 2/8/21 for Quetiapine Fumarate (antipsychotic), take 1 tablet every night at bedtime; -An order dated 4/15/21 for Fluoxetine HCL	V 118		

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(sedative) 20 mg, take 1 capsule every day;
-Medication Error Report dated 2/16/21 completed by facility staff indicated Fluoxetine HCL wasn't administered because there was none available;
-An order dated 2/1/21 for Lamotrigine (anticonvulsant) 100 mg, take 1 tablet by mouth daily;
-Medication Error Reports dated 2/3/21 - 2/4/21 completed by facility staff indicated Lamotrigine was not administered because there was none available.

Review on 5/21/21 of client #2's MARs for February 2021 revealed:
-Fluoxetine HCL 20 mg, take 1 capsule every day had lines drawn through 2 days (2/1/21 - 2/1/21) and circled initials for 3 days (2/3/21, 2/16/21 - 2/17/21) that indicated the medication had not been administered;
-There was no reason documented as to why Fluoxetine HCL was not administered for 5 days;
-Amphetamine-Dextroamphetamine 20 mg, take 1 tablet by mouth every day in the am had 2 days with lines drawn through them;
-There was no reason documented as to why Amphetamine-Dextroamphetamine was not administered 2 days;
-Lamotrigine 100 mg, take 1 tablet by mouth every am had 2 days with lines drawn through 2/1/21 - 2/2/21 and 2 days with circled initials 2/3/21 - 2/4/21;
-There was no documentation as to why Lamotrigine was not administered 4 days;
-Trazodone 50 mg, take 1 tablet by mouth at bedtime had lines drawn through 2 days 2/1/21 - 2/2/21;
-There was no documentation as to why Trazodone was not administered 2 days;
-Quetiapine Fumarate, take 1 tablet every night at

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bedtime had lines drawn through 2 days 2/1/21 - 2/2/21;
-There was no documentation as to why Quetiapine Fumarate was not administered 2 days.

Review on 5/21/21 of client #2's MAR for March 2021 revealed:
-Trazodone 50 mg, take 1 tablet by mouth at bedtime had 3 blanks (3/4/21, 3/6/21 and 3/18/21);
-Quetiapine Fumarate, take 1 tablet every night at bedtime had 3 blanks (3/4/21, 3/6/21, and 3/18/21);
-There was no documentation as to why 3 doses of Trazodone and Quetiapine Fumarate was not administered;
-Cetirizine HCL 1 mg/1 ml syrup, take 1 teaspoon by mouth every day at bedtime had 9 blanks (3/4/21, 3/6/21 - 3/7/21, 3/11/21 - 3/13/21, 3/15/21, 3/18/21 and 3/25/21);
-There was no documentation as to why 9 doses of Cetirizine HCL was not administered.

Review on 4/30/21 of client #2's MAR for April 2021 revealed:
-Amphetamine-Dextroamphetamine 20 mg, take 1 tablet by mouth in the am had circled initials on 4/4/21 - 4/17/21 indicating the medication wasn't administered;
-Documentation on the back of the MAR on 4/10/21 indicated Amphetamine-Dextroamphetamine wasn't administered because there was none available;
-Cetirizine HCL 1 mg/ml, take 1 teaspoon by mouth every day at bedtime had circled initials on 4/20/21 - 4-21/21 and blanks on 4/28/21 and 4/30/21 - 4/31/21 indicating the medication wasn't administered;
-There was no documentation regarding why

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V 118	Continued From page 22 client wasn't administered 5 doses of Cetirizine HCL. Finding 4: The facility failed to have an order for 1 medication that had been administered to client #3. Review on 4/30/21 of client #3's MAR for April 2021 revealed Guanfacine HCL Extended Release (ER) (used to treat ADHD) 3 mg, take 1 tablet by mouth twice daily was documented as being administered 27 out of 30 mornings and 27 out of 29 evenings. Review on 4/30/21 of client #3's record revealed no documentation of an order for Guanfacine HCL ER. Finding 5: The facility failed to administer 2 medications as ordered and maintain current MAR's for client #3 for the months of February 2021 - April 2021. Review on 4/30/21 of client #3's record revealed: -An order dated 1/6/21 for Aripiprazole (used to treat irritability with autism) 2 mg, take 1 tablet by mouth daily; -Medication Error Reports dated 4/23/21, 4/25/21 - 4/27/21 completed by facility staff indicated Aripiprazole was not administered because it wasn't available; -An order dated 1/6/21 for Bupropion HCL (antidepressant) Sustain Release (SR) 100 mg, take 1 tablet by mouth every am; -Medication Error Report dated 2/8/21 completed by facility staff indicated Bupropion HCL was not administered because it was not available. Review on 5/21/21 of client #3's MAR for February 2021 revealed:	V 118		

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V 118	Continued From page 23 -Aripiprazole 2 mg, take 1 tablet by mouth daily had 1 blank (2/21/21); -Bupropion HCL SR 100 mg, take 1 tablet by mouth every am had 1 blank (2/21/21); -There was no documentation as to why 1 dose each of Aripiprazole and Bupropion HCL were not administered. Review on 5/21/21 of client #3's MAR for March 2021 revealed: -Aripiprazole 2 mg, take 1 tablet by mouth daily had 1 blank 3/1/21; -Bupropion HCL SR 100 mg, take 1 tablet by mouth every am had 1 blank 3/1/21; -There was no documentation as to why 1 dose each of Bupropion HCL and Aripiprazole was not administered. Review on 4/30/21 of client #3's MAR for April 2021 revealed: -Aripiprazole 2 mg, take 1 tablet by mouth daily had circled initials on 4/22/21 - 4/30/21 indicating the medication had not been administered; -Documentation on the back of the MAR on 4/24/21, 4/26/21 - 4/30/21 indicated Aripiprazole was not administered because the medication wasn't available. Interview on 4/30//21 with client #3's guardian revealed: -She was not aware that client #3 had missed doses of medications during the months of February 2021 - April 2021; -Medications were discussed during every monthly meeting and she had never been informed there was an issue with medications. Interview on 5/20/21 with a pharmacy representative revealed: -Facility staff rotate around between their location	V 118		

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and their sister location;
-The pharmacy had no issues during February 2021 - April 2021 with not being able to get medications;
-The issues were with the medications being called in after medications had ran out and with there being no refills available.

Interview on 5/10/21 with staff #2 revealed:
-There had been an issue with the clients' medications not being available;
-"I guess they're just forgetting to get them refilled in time;"
-Ensuring medications were filled had been the responsibility of the Qualified Professional (QP) but since she had been out on medical leave, that had become the House Manager's (HM) responsibility;
-The HM had informed her that she was unable to get the medical providers to return her telephone calls regarding refills, but she was unable to remember when this was discussed.

Interview on 5/11/21 with staff #3 revealed:
-There had been an issue with the clients' medications not being available;
-The HM was responsible for ensuring medications were available;
-The HM had informed her the pharmacy was having issues getting the medications, but she was unable to remember when this was discussed.

Interview on 5/14/21 with staff #4 revealed:
-There had been an issue with the clients' medications not being available;
-"Most of the time it's a psychotropic medication and we can't get [the pharmacy] to fill it;"
-The pharmacy hadn't been filling the medications because there were no refills;

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V 118	Continued From page 25 -Facility staff were not able to get in contact with the medical provider in order to obtain refills for the medications; -"We would email her, call her and she would never respond...she wouldn't communicate at all." Interview and record review on 4/30/21 with the HM revealed: -She was not aware that medication orders for clients #1 and #3 were not available; -All 3 clients had been out of medications because the medical provider hadn't called in refills to the pharmacy; -An email she had sent to the medical provider was reviewed and included, ..."4/5/21...we are in need of med refill for the residents...[client #2] Amphetamine-Dextroamphetamine 10 mg and 20 mg;" -She was unable to explain why client #2 was out of the medication from 4/3/21 - 4/17/21; -She was unable to provide documentation of any additional attempts to get the medication filled; -Additional emails reviewed that the HM had sent to the medical provider were dated 2/9/21 and 3/12/21 and the medical provider had responded the same day. Interview on 5/21/21 with the Associate Professional revealed: -She was aware there were issues with orders and medications not being available and the MAR's not being completed accurately; -The cause of the orders and medications not being available was the medical provider; -"She (the medical provider) is hard to get a hold of sometimes;" -She had been informed by the HM that the Owner was looking at switching the clients to a new medical provider.	V 118		

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HORIZONS KIDS	2655 WILES RIDGE ROAD HAYS, NC 28635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 26 Interview on 4/30/21 with the Licensed Professional revealed: -She was not sure why there were not medication orders available for clients #1 and #3; -It was the House Managers responsibility to ensure that MARs were current; -It was her responsibility in the absence of the QP to ensure that medication orders were available, medications were administered as ordered and MARs were documented. Interview on 5/21/21 with the Owner revealed: -The issue with the medications was primarily because of the medical provider not being available and not returning messages; -"We're going to switch over to another provider;" -The clients current medical provider saw the clients for free and if they switched to a different provider there was going to be a $75 monthly fee for each client; -"We're just going to work around that ($75 fee);" -He was aware that staff were not accurately documenting the MARs; -He thought the documentation issue was caused by the staff not being trained in how to correctly utilize the facilities MARs; -"They (facility staff) will actually get trained on the form that we use." Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician. Review on 5/21/21 of the first Plan of Protection written by the Owner dated 5/21/21 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Horizons Kids will conduct an agency-wide training regarding above rule and will completed	V 118		

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V 118	Continued From page 27	V 118		

another Medication Administrative Training with a certified RN. This will be completed within 23 days of Cited date 05/21/2021.
Describe your plans to make sure the above happens.
(V118) Human Resource Manager New Hire Effective 06/01/21 will be responsible."

This facility is a 24-hour, residential treatment staff secure facility which serves clients requiring continuous supervision, behavioral interventions and a high level of support to meet their needs. There are currently 3 clients ages 9 and 11 residing in the facility with diagnoses including Autism, Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Adjustment Disorder and Major Depressive Disorder. The facility failed to administer medications as ordered and to maintain MARs for 3 clients. There were medication orders missing for 2 clients. Client #1 missed 11 doses of medications that included antipsychotics, sedatives and medications used to treat ADHD during the month of March 2021. Client #1 missed 34 doses of medications that included antipsychotics, sedatives, and medications used to treat ADHD, bed wetting and allergies during the month of April 2021. Client #2 missed 15 doses of medications that included sedatives, stimulants, anticonvulsants, antidepressants and antipsychotics during the month of February 2021. Client #2 missed 15 doses of medications that included antidepressants, antipsychotics and medications used to treat allergies during the month of March 2021. Client #2 missed 19 doses of medications that included stimulants and medications used to treat allergies during the month of April 2021. Client #3 missed 2 doses of medications that included an antidepressant and medications used

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V 118	Continued From page 28 to treat irritability during the months of February 2021 - March 2021. Client #3 missed 9 doses of medications used to treat irritability during the month of April 2021. The facility's failures to administer medications as ordered and document MARs constitutes a Type A1 Rule violation for serious neglect of the clients and must be corrected within 23 days. An administrative penalty of $2,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23 day.	V 118		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure the Health Care Personnel Registry (HCPR) was accessed prior to employment affecting 2 of 2 former staff (FS (#7 and #8)) and 2 of 7 audited current staff (#1 and the House Manager (HM)). The findings are:	V 131		

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V 131	Continued From page 29 Review on 5/11/21 of FS #7's personnel record revealed: -A hire date of 1/7/21; -A termination date of 3/30/21; -Documentation that the HCPR was accessed on 1/11/21. Review on 4/30/21 of FS #8's personnel record revealed: -A hire date of 12/1/20; -A termination date of 2/7/21; -Documentation that the HCPR was accessed on 12/14/20. Review on 4/30/21 of staff #1's personnel record revealed: -A hire date of 1/6/21; -Documentation that the HCPR was accessed on 1/11/21. Review on 4/30/21 of the HM's personnel record revealed: -A hire date of 12/2/20; -Documentation that the HCPR was accessed on 12/14/20. Interview on 4/30/21 with the Licensed Professional revealed it was the responsibility of Human Resources to ensure that the HCPR was accessed prior to employment. Interviews on 5/21/21 and 6/4/21 with the Owner revealed: -It was the responsibility of HR to access the HCPR for each employee; -He was aware that the HCPR should be accessed prior to employees beginning work; -HR was not available to be interviewed because she was on vacation and then resigned on 5/23/21.	V 131		

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V 131	Continued From page 30 This deficiency is cross referenced into 10A NCAC 27G .1700 SCOPE (V293) for a Type B rule violation and must be corrected within 45 days.	V 131		
V 133	G.S. 122C-80 Criminal History Record Check G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT. (a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. (b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of	V 133		

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V 133	Continued From page 31 Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public	V 133		

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V 133	Continued From page 32	V 133		

records obtained from a State agency.
(c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant:
(1) The level and seriousness of the crime.
(2) The date of the crime.
(3) The age of the person at the time of the conviction.
(4) The circumstances surrounding the commission of the crime, if known.
(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.
(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.
(7) The subsequent commission by the person of a relevant offense.
The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.
(d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for:
(1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual.
(2) Failure to check an employee's history of criminal offenses if the employee's criminal

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history record check is requested and received in compliance with this section.
(e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina

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V 133	Continued From page 34 Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5. (f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor. (g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met: (1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10. (2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.) This Rule is not met as evidenced by: Based on record reviews and interview the facility failed to request state criminal background checks within five business days of employment for 1 of 2 former staff (FS) (#8) and 1 of 7 current staff (the House Manager (HM)). The findings	V 133		

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V 133	Continued From page 35 are: Review on 4/30/21 of FS #8's personnel record revealed: -A hire date of 12/1/20; -A termination date of 2/7/21; -Documentation that a criminal background check was requested on 12/14/20. Review on 4/30/21 of the HM's personnel record revealed: -A hire date of 12/2/20; -Documentation that a criminal background check was requested on 12/14/20. Interview on 4/30/21 with the Licensed Professional revealed it was the responsibility of Human Resources (HR) to ensure that the criminal background check was requested timely. Interviews on 5/21/21 and 6/4/21 with the Owner revealed: -It was the responsibility of HR to request state criminal background checks timely; -He was aware that criminal background checks were required to be requested within 5 business days of employment; -HR was not available to be interviewed because she was on vacation and then resigned on 5/23/21. This deficiency is cross referenced into 10A NCAC 27G .1700 SCOPE (V293) for a Type B rule violation and must be corrected within 45 days.	V 133		
V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE	V 293		

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V 293	Continued From page 36 (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to a community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility	V 293		

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V 293	Continued From page 37 shall coordinate with other individuals and agencies within the child or adolescent's system of care. This Rule is not met as evidenced by: Based on interviews, record reviews, and observations, the facility failed to include individualized supervision and structure of daily living, minimize the occurrence of behaviors related to functional deficits, ensure safety and deescalate out of control behaviors, and coordinate with other individuals and agencies within the child or adolescent's system of care affecting 3 of 3 clients (#1, #2 and #3). The findings are: CROSS REFERENCE: 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) Based on record reviews, interviews and observations, 1 of 3 Qualified Professionals (QP) (the Licensed Professional (LP)) failed to demonstrate knowledge and skills required by the population served. CROSS REFERENCE: 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110) Based on record review, interviews and observations, Paraprofessionals failed to demonstrate competency in decision making	V 293		

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V 293	Continued From page 38 skills for 2 of 6 audited staff (#3 and #6). CROSS REFERENCE: 10A NCAC 27G .0205 Assessment and Treatment/Rehabilitation or Service Plan (V112) Based on record reviews and interviews, the facility failed to develop and implement strategies to address the needs for 1 of 3 clients (#3). CROSS REFERENCE: 10A NCAC 27G .0207 Emergency Plans and Supplies (V114) Based on record reviews and interviews the facility failed to ensure fire and disaster drills were conducted on each shift and repeated quarterly. CROSS REFERENCE: GS 131E-256 Health Care Personnel Registry (V131) Based on record reviews and interview, the facility failed to ensure the Health Care Personnel Registry (HCPR) was accessed prior to employment affecting 2 of 2 former staff (FS (#7 and #8)) and 2 of 7 audited current staff (#1 and the House Manager (HM)). CROSS REFERENCE: GS 122C-80 Criminal History Record Check Required for Certain Applicants for Employment (V133) Based on record reviews and interview the facility failed to request state criminal background checks within five business days of employment for 1 of 2 former staff (FS) (#8) and 1 of 7 current staff (the House Manager (HM)). CROSS REFERENCE: 10A NCAC 27G .0603 Incident Response Requirements for Category A and B Providers (V366) Based on record reviews and interviews the facility failed to implement written policies governing their response to level I incidents.	V 293		

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V 293	Continued From page 39 CROSS REFERENCE: 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers (V367) Based on record reviews and interviews the facility failed to submit 3 Level II incident reports within 72 hours as required. CROSS REFERENCE: 10A NCAC 27E .0107 Training on Alternatives to Restrictive Interventions (V536) Based on record review and interviews, the facility failed to ensure 1 of 2 former staff (FS) (#7) received training in the use of alternatives to restrictive interventions prior to providing services. CROSS REFERENCE: 10A NCAC 27E .0108 Training in Seclusion, Physical Restraint and Isolation Time-Out (V537) Based on record review and interviews, the facility failed to ensure 1 of 2 former staff (FS) (#7) received Training in Seclusion, Physical Restraint and Isolation Time-Out prior to providing services. CROSS REFERENCE: 10A NCAC 27F .0102 Living Environment (V539) Based on observation and interviews, the facility failed to provide clients accessible areas for personal privacy effecting 3 of 3 clients (#1, #2, and #3). Review on 4/28/21 of client #2's record revealed: -An admission date of 10/30/20; -An age of 9 years old; -Diagnoses included Adjustment Disorder and Oppositional Defiant Disorder (ODD); -Documentation from the local hospital dated 4/11/21 that included, "diagnosed with contusion of the face."	V 293		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 293	Continued From page 40 Interview with client #2's guardian on 5/4/21 revealed: -The client informed her during a video visit she had been restrained by facility staff on 4/4/21; -She had not been informed the client had been restrained on 4/4/21 until she asked several days after the incident occurred; -The client's family had informed her the client had been assaulted by another client on 4/11/21; -She had not been informed the client had been assaulted; -"I actually reached out to the hospital and got more information because the facility was very vague;" -"This group home is not good with communication at all;" -"They (facility staff) always use the excuse they couldn't get the on-call number to work." Interview with client #2's guardian ad litem on 5/5/21 revealed: -She had not been informed by facility staff the client had been restrained on 4/4/21; -She had not been informed by facility staff the client had been assaulted by another client; -When she had asked staff what happened, she was informed loud noises triggered another client to punch client #2 in the face; -"That (the incident and staff not reporting it) scared me;" -"I don't know how many kids (clients) they have but it's hard to get appointments (to talk with client and the LP)." Review on 5/21/21 of the first Plan of Protection written by the Owner dated 5/21/21 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? (V114) Horizons Kids will ensure that all fire	V 293		

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V 293	Continued From page 41	V 293		

plans/exit plans are visible at all required exits and the current approved area-wide disaster plan is accessible to staff at facility. Facility will have First-Aid supplies and accessible for use.
(V110) Horizons Kids Human Resource Department will initiation an Individualized Supervision Plan upon hiring each paraprofessional. Horizons Kids will include Competence Training which will include technical knowledge, cultural awareness, analytical skills, decision-making skills, interpersonal skills, communication skills, and clinical skills. Populated served training will be completed.
(V131) HCPR check will be completed before Date of Hire, Start Date of Training and Start Date in Facility.
(V133) Criminal History Record Checks will be completed before Date of Hire, Start Date of Trainings and State Date in Facility.
(V366) Policy: Horizons Kids, LLC. will ensure that prompt and accurate reporting and immediate evaluation and implementation of corrective and preventive measures take place for each incident or unusual occurrence within the programs. This reporting will be in accordance with all laws, rules and requirements of the regulatory agency of the program in the interest of increasing quality of care and safety, Horizons Kids, LLC. programs shall systematically monitor and evaluate all incidents that adversely affect or have the potential to adversely affect care, safety, rights or dignity of the individuals we support. Definition of Incident: Event that is inconsistent with the routine operation of a service or care of an individual we support that is likely to lead to adverse effects. Types of Incidents that Must Be Reported: Abuse, Neglect, and Exploitation Allegation, Confidentiality Breach, Death, Exposure to Blood Borne Pathogens, Fire, Illegal Act by an Individual, Inappropriate or Illegal

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V 293	Continued From page 42 Sexual Behavior, Injury, Medication Error, Restrictive Intervention, Search and Seizure, Self-Injurious Behavior, Stealing, Threat of Suicide, Homicide, or Violence, Unplanned Absence, Vandalism, Violent Behavior, Crimes Against Individuals Committed by Staff Completion of Incident Reports: Written incident reports shall be completed within 24 hours of the incident by the employee(s) witnessing the incident, or to whom an incident is reported by an individual we support, visitor or others. Reports need to include a detailed description of the event, actions taken on behalf of the individual we support, and their condition following the event. Other witnesses to the incident should also complete an Incident Report form. Facts regarding the incident shall be reported objectively and without unsubstantiated conclusions, opinions or accusations. The Incident Report forms shall not be filed or mentioned in the individual's record. (V367) Completed paper forms shall be submitted to the Program Manager (QP-S) immediately for administrative review and entry into the Incident Response Improvement System (IRIS). All staff responsible for IRIS input/reporting will receive training within seven days of 5/21/21. All IRIS reports will need confirmation and QA/QI check from two trained staff to ensure proper submission. (V536) Horizons Kids Utilized NCI for Restrictive Interventions, and all staff will be trained on NCI prior to entering the facility. All staff will be restrained annually. (V537) All Staff will be trained within 23 days of 5/21/21 regarding the rule above and documentation requirements. (V539) Horizons Kids will ensure and do a facility inspection regarding the above rule within 23 days related Privacy, Safety, Comfort Zone,	V 293		

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V 293	Continued From page 43 Indoor Space Requirements. (V109) Horizons Kids will conduct a Competence Training within 23 days which will include technical knowledge, cultural awareness, analytical skills, decision-making skills, interpersonal skills, communication skills, and clinical skills. Populated served training will be completed. (V112) Person-Centered Training will be provided within the next 30 days to ensure that all residents Person Centered Plans are individualized and accurately reflecting all identified goals per the treatment team and guardian. Residents' goals/activities will not include goals outside of the parameters of the Person-Centered Plan. Individualized goals and treatment planning with be completed for each resident NLT 5/24/21 and carried out as such thereafter. Skills can be taught, modeled, and role-played. Activities of Daily should be carried out independently by each resident. Training will be provided for population specific needs. Describe your plans to make sure the above happens. (V114) New Position Change Effective 06/01/21 Director of Clinical & Administrative Services will be responsible. (V110) Human Resource Manager New Hire Effective 06/01/21 will be responsible. (V131) Human Resource Manager New Hire Effective 06/01/21 will be responsible. (V133) Human Resource Manager New Hire Effective 06/01/21 will be responsible. (V366) Executive Director (Owner) and Director of Clinical & Administrative Services will be responsible (V367) Director of Clinical & Administrative Services will be responsible. (V536) Horizons Contracted NCI Trainer will be responsible for training and Human Resource	V 293		

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V 293	Continued From page 44	V 293		

Manager New Hire Effective 06/01/21 will be responsible for scheduling trainings.
(V537) Executive Director (Owner) and Director of Clinical & Administrative Services will be responsible.
(V539) Human Resource Manager New Hire Effective 06/01/21 will be responsible.
(V109) Human Resource Manager New Hire Effective 06/01/21 will be responsible.
(V112) Director of Clinical & Administrative Services will be responsible."

This facility is a 24-hour, residential treatment staff secure facility which serves clients requiring continuous supervision, behavioral interventions and a high level of support to meet their needs. There are currently 3 clients ages 9 and 11 residing in the facility with diagnoses including Autism, Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Adjustment Disorder and Major Depressive Disorder. There was no documentation that fire and disaster drills were being conducted on each shift and repeated quarterly. There was no documentation that 1 former staff had completed Training on Alternatives to Restrictive Interventions and Training in Seclusion, Physical Restraint and Isolation Time-Out prior to providing services and restraining a client. There was no documentation of a criminal record request for 1 former staff and the House Manager within 5 business days of making the conditional offer of employment. There was no documentation that the Health Care Personnel Registry had been accessed for 2 former staff and the House Manager prior to hiring. There was no documentation regarding a Level I incident that included a client falling and being assessed at the local hospital for arm pain. Two Level II incident reports that included a

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V 293	Continued From page 45 restraint and a client being assaulted by another client were not submitted into the NC IRIS and 1 Level II incident that included a restraint was submitted after 72 hours. There were no window coverings in 2 client bedrooms and 2 client bedrooms had no door. The 1 bedroom that had a door, contained a door handle that locked from the outside of the bedroom. The door handle had been rotated by a Paraprofessional. Another Paraprofessional kicked in a bathroom door with a client inside. The Paraprofessional that kicked the door, failed to document the incident and failed to explain her decision making as she denied being involved in the incident. Qualified Professionals failed to notify a client's guardian or guardian ad litem of 2 incidents that included the client being restrained and assaulted by another client. There were no strategies documented in the Treatment Plans regarding preventing additional incidents of clients assaulting each other while being transported. The cumulative effect of the facility's failures to coordinate care with other agencies, conduct fire/disaster drills, arrange training, develop and implement goals based on client needs, complete incident reports and submit reports into IRIS timely, ensure client safety via personnel checks or Paraprofessionals and Qualified Professionals to demonstrate knowledge, skills, abilities and decision making skills is detrimental to the health, safety and welfare of the clients. This deficiency constitutes a Type B rule violation and must be corrected within 45 days. If the violation is not corrected within 45 days, an additional administrative penalty of $400.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 293		

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V 366	Continued From page 46	V 366		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond	V 366		

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V 366	Continued From page 47 by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not	V 366		

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V 366	Continued From page 48 available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to implement written policies governing their response to level I incidents. The findings are: Review on 4/28/21 of client #1's record revealed: -An admission date of 3/19/21; -An age of 11 years old; -Diagnoses included Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, and Major Depressive Disorder; -Documentation from the local hospital dated 4/6/21 that included, "right arm problem...diagnosis: fall."	V 366		

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V 366	Continued From page 49 Interview on 4/30/21 with client #1 revealed she was unable to remember what happened to her arm or why she had to be assessed at the local hospital because of arm pain. Interview on 5/20/21 with client #1's guardian revealed she was informed by facility staff that client #1 fell while trying to do flips and was complaining of arm pain. Review on 4/28/21 of incident reports revealed no documentation of an injury to client #1's arm. Interview on 5/21/21 with the Qualified Professional revealed: -An incident report should have been completed regarding the incident with client #1; -Staff that were working when an incident occurred were required to complete an incident report and submit it to an incident email. Interview on 5/21/21 with the Owner revealed: -He was not aware of the incident that occurred with client #1 hurting her arm; -It was the responsibility of the staff that were working when incidents occurred to submit incident reports to the incident email; -He reviewed the incident reports that were submitted by staff. This deficiency is cross referenced into 10A NCAC 27G .1700 SCOPE (V293) for a Type B rule violation and must be corrected within 45 days.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR	V 367		

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V 367	Continued From page 50 CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (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:	V 367		

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V 367	Continued From page 51 (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided 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 52	V 367		

This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to submit 3 Level II incident reports within 72 hours as required. The findings are:

Review on 4/28/21 of client #1's record revealed:
-An admission date of 3/19/21;
-An age of 11 years old;
-Diagnoses included Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, and Major Depressive Disorder.

Review on 4/28/21 of client #2's record revealed:
-An admission date of 10/30/20;
-An age of 9 years old;
-Diagnoses included Adjustment Disorder and Oppositional Defiant Disorder;
-Client #2 was seen at the local hospital on 4/11/21 and was diagnosed with contusion of the face.

Following are examples of Level II incident reports that were not submitted timely.

Finding 1:

Interview on 4/30/21 with client #1 revealed she had been restrained while being at the facility.

Review on 4/30/21 of facility incident reports for client #1 revealed:
-"Date of incident: 04/06/2021 Time: 6:00 PM Staff attempted to redirect [client #1] then [client

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#1] saw her peer and kicked peer as she walked up the stairs...staff put [client #1] into a therapeutic hold for 2 minutes and 35 seconds to ensure the safety of [client #1], staff and peers...after the therapeutic hold [client #1] was able to return to a calm normal state."

Review on 4/29/21 of the Incident Response Improvement System (IRIS) revealed no documentation regarding client #1 being restrained.

Interview on 5/13/21 with staff #5 revealed:
-She and the House Manager had restrained client #1;
-"So, we had to restrain her to calm her down and keep her from harming any of the other girls...we restrained her for, I'd say about 4 minutes."

Interview on 5/21/21 with the Qualified Professional (QP) revealed:
-The Licensed Professional (LP) had been responsible for submitting incident reports into the IRIS;
-Now that she had returned to work from medical leave, she was going to take over that duty.

Interview on 4/30/21 with the LP revealed:
-The incident report should have been submitted into the IRIS;
-She checked the IRIS during the interview and discovered the incident had been partially submitted but it had not been completed.

Finding 2:

Interview on 5/12/21 with client #2 revealed:
-She had been assessed at the local hospital due to a nose bleed;
-She had been sitting in the back seat of the

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facility van with client #3;
-"We was going to the park and I was just singing, minding my own business and she (client #3) started hitting me;"
-"I screamed and started crying."

Review on 4/29/21 of the IRIS revealed no documentation regarding client #2 being assaulted by client #3.

Interview on 5/13/21 with staff #4 revealed:
-She had been working the day client #3 assaulted client #2;
-"We (staff) see [client #3] just hit her in the face over and over and over;"
-Client #2 was assessed at the local hospital;
-She had notified the LP and the QP by telephone and had emailed them both an incident report;
-She was not sure who was responsible for entering information into the IRIS.

Interview on 5/13/21 with staff #5 revealed:
-She had been working the day client #3 assaulted client #2;
-Clients #2 and #3 were both sitting in the back seat of the facility van
-Client #2 had been singing and client #3 had asked her to stop;
-"She (client #3) just went off the deep end...we pulled over as soon as we heard the altercation;"
-Client #2 was assessed at the local hospital.

Interview on 5/21/21 with the QP revealed:
-The LP had been responsible for submitting incident reports into the IRIS;
-Now that she had returned to work from medical leave, she was going to take over that duty.

Finding 3: This incident was not reported within 72 hours.

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V 367	Continued From page 55 Review on 4/29/21 of the North Carolina Incident Response Improvement System (IRIS) revealed: -A report submitted 4/9/21 by the LP included, "date of incident: 4/4/21...client (#2) was upset after being redirected for trying to spit on another resident...client went inside to re-group away from the group...client (#2) was in her room attempting to tie her mask around her neck and then ran to her window and attempted to tie blinds around her neck...client (#2) was placed in a standing restraint for 60 seconds while staff removed blinds string from around her neck...legal guardian was contacted on 04/05 and informed that client (#2) was placed in a restraint for her safety." This deficiency is cross referenced into 10A NCAC 27G .1700 SCOPE (V293) for a Type B rule violation and must be corrected within 45 days.	V 367		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or	V 536		

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property damage is prevented.
(c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered.
(d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(e) Formal refresher training must be completed by each service provider periodically (minimum annually).
(f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.
(g) Staff shall demonstrate competence in the following core areas:
(1) knowledge and understanding of the people being served;
(2) recognizing and interpreting human behavior;
(3) recognizing the effect of internal and external stressors that may affect people with disabilities;
(4) strategies for building positive relationships with persons with disabilities;
(5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;
(6) recognizing the importance of and assisting in the person's involvement in making decisions about their life;
(7) skills in assessing individual risk for escalating behavior;
(8) communication strategies for defusing and de-escalating potentially dangerous behavior;

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V 536	Continued From page 57 and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course;	V 536		

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V 536	Continued From page 58 (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers.	V 536		

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V 536	Continued From page 59 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 2 former staff (FS) (#7) had training in the use of alternatives to restrictive interventions prior to providing services. The findings are: Review of FS #7's personnel record on 4/11/21 revealed: -A hire date of 1/7/21; -A termination date of 3/30/21; -No documentation that Training on Alternatives to Restrictive Interventions had been completed. Interview on 5/20/21 with FS #7 revealed: -She remembered the day she received all her training, including First Aid that alternatives to restrictive interventions was mentioned; -She was unable to remember who discussed the alternatives to restrictive interventions with her or details of what was said. Interview on 4/30/21 with the Licensed Professional revealed it was the responsibility of Human Resources (HR) to ensure all trainings had been completed. Interview on 5/21/21 with the Owner revealed: -He was sure FS #7 had completed Training on Alternatives to Restrictive Interventions; -HR had contacted the trainer but hadn't received verification the training had been completed. This deficiency is cross referenced into 10A NCAC 27G .1701 SCOPE (V293) for a Type B rule violation and must be corrected within 45 days.	V 536		

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V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.	V 537		

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V 537	Continued From page 61 (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.	V 537		

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V 537	Continued From page 62 (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually.	V 537		

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V 537	Continued From page 63 (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 2 former staff (FS) (#7) received Training in Seclusion, Physical Restraint and Isolation Time-Out prior to providing services. The findings are: Review of FS #7's personnel record on 4/11/21 revealed: -A hire date of 1/7/21; -A termination date of 3/30/21; -No documentation that Training in Seclusion, Physical Restraint and Isolation Time-Out had	V 537		

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V 537	Continued From page 64 been completed. Interview on 5/20/21 with FS #7 revealed: -She remembered the day she received all her training, including First Aid that restraints were mentioned; -She was unable to remember who discussed restraints with her or details of what was said; -She had restrained 2 former clients while she was employed. Interview on 4/30/21 with the Licensed Professional revealed it was the responsibility of Human Resources to ensure that all trainings had been completed. Interview on 5/21/21 with the Owner revealed: -He was sure that FS #7 had completed Training in Seclusion, Physical Restraint and Isolation Time-Out; -HR had contacted the trainer but hadn't received verification the training had been completed. This deficiency is cross referenced into 10A NCAC 27G .1700 SCOPE (V293) for a Type B rule violation and must be corrected within 45 days.	V 537		
V 539	27F .0102 Client Rights - Living Environment 10A NCAC 27F .0102 LIVING ENVIRONMENT (a) Each client shall be provided: (1) an atmosphere conducive to uninterrupted sleep during scheduled sleeping hours, consistent with the types of services being provided and the type of clients being served; and (2) accessible areas for personal privacy, for at least limited periods of time, unless	V 539		

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V 539	Continued From page 65 determined inappropriate by the treatment or habilitation team. (b) Each client shall be free to suitably decorate his room, or his portion of a multi-resident room, with respect to choice, normalization principles, and with respect for the physical structure. Any restrictions on this freedom shall be carried out in accordance with governing body policy. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to provide clients accessible areas for personal privacy effecting 3 of 3 clients (#1, #2, and #3). The findings are: Observation from approximately 11:00am - 11:30am revealed: -The bedroom of client #1 on the right of the hallway bathroom had no door; -The bedroom of client #2 on the left of the hallway bathroom had no door and no window coverings; -The double bedroom of client #3 had no window coverings; -The bedroom closets had doors and the closets were approximately 2 1/2 feet deep, 5 1/2 feet wide and the hanging rod was 5 feet high. Interview on 4/30/21 with client #1 revealed: -She had not had a bedroom door since she was admitted in March 2021; -She had asked different staff for a bedroom door and was informed they hadn't gotten around to installing it yet; -"I want one (bedroom door) so I don't have to change in my closet."	V 539		

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V 539	Continued From page 66 Interview on 4/29/21 with client #1's guardian revealed: -Client #1 had not had a bedroom door since she was admitted in March 2021; -She had been informed when client #1 was admitted that a door was going to be installed; -"I mean, I would like for her to have a door so she could change privately." Interview on 5/12/21 with client #2 revealed: -She was admitted to the facility in October 2020; -She didn't like not having a bedroom door because her belongings were being stolen; -She had been in another bedroom that had a door but was moved to her current bedroom approximately 3 weeks prior; -A former client had been in her current bedroom and the door was removed because she was slamming and locking the door; -The blinds in her bedroom had been removed because they were a safety hazard for her; -She had never seen any other window coverings in the bedrooms. Interview on 4/28/21 with staff #1 revealed: -Two of the bedroom doors had been removed because the current clients were locking themselves in their bedrooms; -"They (the clients) will lock themselves in their room and we don't know what they're doing...they do it often;" -Client #3 was the only client with a bedroom door because "she's not a problem;" -Client #2 and a former client were attempting to harm themselves with the blinds in their bedrooms, so the blinds were removed. Interview on 5/10/21 with staff #2 revealed: -The blinds in 2 of the bedrooms had been removed because a former client and client #2	V 539		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 539	Continued From page 67	V 539		

were wrapping the cords around their necks;
-She had never seen any other type of window coverings in the bedrooms;
-The doors of 2 bedrooms were removed because 2 former clients were locking themselves in their bedrooms;
-"When they (clients) do that (lock themselves in the bedrooms), we take the door down;"
-"That (having a bedroom door) is a privilege;"
-Bedroom doors were always required to be open;
-After the former clients left the facility, the blinds and bedroom doors were never reinstalled.

Interview on 5/11/21 with staff #3 revealed:
-The blinds in client #2's bedroom were removed because she was trying to wrap the cord around her neck;
-The blinds in client #3's bedroom were removed when client #2 was in that room and they had never been reinstalled;
-She had never seen any other type of window coverings in the bedrooms;
-She was not sure why 2 of the bedrooms had no doors.

Interview on 5/14/21 with staff #4 revealed:
-She had been employed since December 2020;
-The blinds in 2 of the bedrooms had been removed prior to her employment;
-She had never seen any other window coverings in the bedrooms;
-Two of the bedroom doors had been removed since her employment;
-A former client had been in both bedrooms and she refused to stop putting her fingers in the outlets so staff removed the doors;
-The doors had never been reinstalled.

Interview on 5/14/21 with staff #5 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL097-081	A. BUILDING: _____ B. WING _____	06/04/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 539	Continued From page 68 -She had been employed since February 2021; -Two of the bedroom doors had been removed in March 2021 because the clients were closing the doors and trying to harm themselves; -The blinds in 2 of the bedrooms were removed because a former client and client #2 had been attempting to harm themselves with them; -The blinds had not been reinstalled after the former client was discharged; -She had never seen any other type of window coverings in the bedrooms. Interview on 5/14/21 with staff #6 revealed: -Two of the bedroom doors had been removed because the current clients were slamming them; -The blinds in 2 of the bedrooms had been removed because client #2 had attempted to harm herself with the cords; -When the clients were moved to different bedrooms, the blinds were not reinstalled; -She had never seen any other type of window coverings in the bedrooms. Interview on 5/21/21 with the Associate Professional revealed: -She had been employed for 2 years; -The blinds in 2 of the bedrooms were removed because a former client and client #2 were attempting to harm themselves with the cords; -The blinds were never reinstalled in the bedrooms once they were removed; -Client #1's bedroom door had been removed prior to her admittance; -A former client was in client #1's bedroom and she kept locking herself in the bedroom; -She was not aware of why client #2's bedroom door had been removed; -Clients were not allowed to close their bedroom doors unless they were getting dressed.	V 539		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL097-081	A. BUILDING: _____ B. WING _____	06/04/2021

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V 539	Continued From page 69 Interview on 5/21/21 with the Qualified Professional revealed: -The blinds had been removed from 2 bedrooms because a former client and client #2 had been attempting to harm themselves with the cords; -The blinds were never reinstalled after the former client was discharged; -Two of the bedroom doors had been removed because the clients were locking themselves in the rooms; -"The doors just became a really big issue." Interview on 5/21/21 with the Owner revealed: -The clients had been locking themselves in the bedrooms and attempting to use the cords on the blinds to harm themselves; -"The best decision was take the blinds down, take the doors down." This deficiency is cross referenced into 10A NCAC 27G .1700 SCOPE (V293) for a Type B rule violation and must be corrected within 45 days.	V 539		