STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL081-127	A. BUILDING: _____ B. WING _____	R 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOOTHILLS AT RED OAK RECOVERY	517 CUB CREEK ROAD ELLENBORO, NC 28040

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual, follow up, and complaint survey was completed on June 11, 2021. The complaint was unsubstantiated (NC# 00177225). Deficiencies were cited. The facility is licensed for the following service category: 10A NCAC 27G.5600D Supervised Living for Minors with Substance Abuse Disorders.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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V 112	Continued From page 1	V 112		

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 current clients (Client #2) and 1 of 2 Former Clients (FC #4) audited. The findings are:

Review on 5/27/21 of Client #2's record revealed:
-admitted 4/29/21.
-17 years old.
-diagnoses of Cannabis Use Disorder, severe; Major Depressive Disorder, severe, recurrent episode.

Review on 5/27/21 of Client #2's "Admission Clinical Safety Screen" dated 4/28/21 revealed:
-reported suicidal and/or self-harm thoughts.
-when felt so overwhelmed would cut self, do a tattoo, or punch something.
-reported punching a wall yesterday and cutting a month ago.
-attempted suicide "Yesterday, when I stabbed myself in the throat with a fork."

Review on 5/27/21 of Client #2's Biopsychosocial Assessment dated 4/29/21 revealed:
-reported trauma history of emotional, physical and sexual abuse.
-reported current and history of suicidal ideation, homicidal ideation and self-harm behaviors.

Review on 5/27/21 of "Level Watch Forms" for Client #2 from 4/29/21 to 5/27/21 revealed:
-5/5/21 - client was currently on level II watch

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(heightened level of supervision).
-revealed plan to self-harm by scratching and showed staff scratches from the previous evening.
-also reported he thought about drinking chemical agents.
-client placed on level III watch (high risk for suicide or self-harm).

Review on 6/2/21 of facility incident reports for Client #2 from 4/29/21 to 5/27/21 revealed:
-5/12/21 - noticed during morning medications client had multiple scratches on his forearm.
-client reported he used his fingernails to scratch himself on 5/10/21.
-medical staff assessed and determined they were superficial scratches and did not need bandages.

Review on 5/27/21 and 6/10/21 of Client #2's "Master Treatment Plan" dated 5/7/21 and last updated 6/2/21 revealed:
-two areas listed as the "Master Problem List" were Cannabis Use Disorder, and Major Depressive Disorder.
-there were no goals or strategies that addressed the client's self-harm and/or suicidal ideations and his trauma history.
-on 6/2/21 added to the Problem/Priority of Major Depressive Disorder was a goal to continue to assess the client's self-harm and/or suicidal ideation.
-there were no strategies provided for the client and direct care staff to assist in decreasing self-harm and suicidal ideation.

Interview on 5/26/21 with Client #2 revealed:
-he scratched himself intentionally when he was first admitted.
-he had cut himself on his wrist since admission.

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V 112	Continued From page 3	V 112		

-he disclosed to the staff he had self-harmed and they put him on a level watch.
-the last time he self-harmed was last Monday (5/17/21) - with the clip off of a pen/pencil.
-the staff were not aware of this.

Interview on 6/1/21 with Therapist #2 revealed:
-he was Client #2's therapist.
-he was aware of the client's self-harming and suicidal ideation.
-different level watches were used to supervise the client closer depending on the severity of the self-harm or threat.
-goals on the treatment plans were based on the client's diagnoses.
-self-harm would be addressed under a diagnosis goal, for example under Depression, "...continuing to assess..." for suicidal or homicidal ideation.
-the therapist was responsible to develop and update client treatment plans.

Review on 5/28/21 of FC #4's record revealed:
-admitted 1/6/21.
-17 years old.
-diagnoses of Cannabis Use Disorder, severe; Alcohol Use Disorder, moderate; Parent-Child Relational Problem, mild; Major Depressive Disorder, recurrent episode, with mixed features.
-4/1/21 - "Therapeutic Discharge"

Review on 5/28/21 of FC #4's "Admission Clinical Safety Screen" dated 1/6/21 revealed:
-a history of suicidal and self-harm thoughts.
-his last suicidal thought was November of 2020.
-last self-harm was superficial cuts on his wrists and arms when he was 12 years old.
-a history of elopement from another facility.
-he had no thoughts of running from this facility.

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V 112	Continued From page 4 Review on 5/28/21 of FC #4's Biopsychosocial Assessment dated 1/12/21 revealed: -"...Client presents with major depressive disorder as evidenced by general daily sadness, low self-worth, thoughts of suicide, low energy, and low motivation at times..." Review on 6/8/21 of "Level Watch Forms" for FC #4 from 2/15/21 to 4/1/21 revealed: -2/15/21 - level I watch - suicidal ideation - eyesight - staff sat outside door during sleep. -3/8/21 - level watch III - threats of suicide with method - sleep separate from community with two staff present. -3/12/21 - level watch II - threatened to kill self and how - self-harm ideations to smash head in wall. -3/23/21 - level III watch - multiple elopement attempts. Review on 6/4/21 of a statement dated 2/25/21 at approximately 6:00 p.m. entitled "Incident with [FC #4]" and signed by Former Staff (FS) #3 revealed: -the client ran from his bedroom to outside the facility. -three staff members followed the client as he began sprinting down the driveway. -FS #1 wrapped his arms around the client and both fell to the ground. -FS #1 held him on the ground for a few seconds. -client was laying on the ground crying and screaming. -he got up and appeared to be heading back to facility when he darted away behind the facility and towards the tree line. -FS #1 tried to wrap his arms around him again and they both fell to the ground again. -client was on the ground again screaming and cursing.	V 112		

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V 112	Continued From page 5 -FS #1 continued to hold the client on the ground in a "bear hug." -the client de-escalated and agreed to walk back to the house. Review on 6/4/21 of facility incident reports for FC #4 from 3/20/21 to 4/1/21 revealed: -3/20/21 - wandering/elopement - client became frustrated and walked out of house towards wooded trail on campus; staff followed - client was out of sight for brief time - client found sitting by tree crying - client returned on own; recommended Primary Therapist work with direct care staff to develop strategies when client needs to take space. -3/25/21 - wandering/elopement - upset with staff for intervening when he took a fork out of the kitchen - client angrily threw the fork down and walked out the front door - went down the driveway and onto the road - claimed he wanted to get kicked out of the program and made comments about getting himself hit by a car; returned on own; placed on a level III watch; met with Primary Therapist and discussed alternative methods of obtaining support when needed. (No alternative methods were listed). -4/1/21 - 6:00 p.m. - wandering/elopement - client walked "...angrily..." down the driveway, frustrated about his level watch; got inside an unlocked car in the parking lot; sat for approximately 20 minutes before returning on his own. -4/1/21- 10:15 p.m. - wandering/elopement - client opened front door of facility at 10:15 p.m. setting off alarm; went to road; two staff members followed; finally agreed to talk; after about 30 minutes client agreed to walk back to facility. Review on 5/28/21 and 6/10/21 of FC #4's Master Treatment Plan dated 1/20/21 with updates on 3/3/21 and 3/23/21 revealed:	V 112		

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V 112	Continued From page 6 -the "Master Problem List" as Substance Use Disorders, Parent-Child Relational Problem and Major Depressive Disorder. -the most recent update on 3/23/21 identified a new problem of Suicidal Ideation - recurrent or ongoing suicidal ideations without any plans. -goals included to alleviate the suicidal impulses/ideations and stabilize the suicidal crisis. -there were no strategies provided for the client and direct care staff to assist in decreasing suicidal ideations and elopement behaviors. Interview attempted on 6/8/21 with FC #4. He did not return the call. Interview on 6/1/21 and 6/9/21 with Therapist #1 revealed: -she was FC #4's therapist. -the client had a history of "wishy-washy" elopement attempts in that he would not try to escape but he would frequently walk off and not tell staff. -the therapist was responsible to create goals and complete client treatment plans. -she remembered adding suicidal ideation in the treatment plan review after he disclosed this to her. -there are pre-populated areas in the electronic record for treatment planning - as far as she knew there was not an area to add elopements to the treatment plan. -she notified the direct care staff of different strategies to try with clients either through meetings, email or it could be just as passing by. Review of FC #4's record revealed there were no strategies documented in the client's record. Review on 6/10/21 of the Plan of Protection dated	V 112		

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V 112	Continued From page 7 6/10/21 written by the Executive Director revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? When an Incident Report for unsafe behavior (SI [Suicidal Ideation], SH [Self-Harm], Elopement) is created the unsafe behavior will be added to the clients Treatment Plan by their primary therapist as soon as possible. This addition will include an identification of the concerning behavior and a list of strategies to address and support the client in reducing and eliminating the behavior. These strategies will then be shared with all staff working with the client via email. Clinical Director [name] will review Incident Reports as they are created and ensure that the identified issue and strategies have been added to the clients Treatment Plan. Describe your plans to make sure the above happens. As the Executive Director I review and sign off on IR [Incident Report] and can ensure that this plan is enacted." Review on 6/11/21 of a revised Plan of Protection dated 6/11/21 written by the Executive Director revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? The plan below will be in place beginning 6/11/21; Upon admission to the program, Clinician will conduct initial safety screen with the client to assess any safety concerns including SI, SH, and	V 112		

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elopement risk. Once completed, this assessment will be available electronically in client's chart. Clinician also disseminates results of this assessment electronically to all staff via email when it is finished. Any identified safety concerns indicated in the email to staff will include strategies and interventions for staff to utilize in support of the client.

The Clinician then conducts an initial intake assessment within the first 24 hrs after admission and completes a biopsychosocial assessment within 72hrs to gather client information. To create an effective treatment plan, Clinicians will also thoroughly review all application and enrollment documents including previous treatment summaries, psychological testing, initial application, and any other relevant materials prior to completing the treatment plan. With information from assessments and intake documents, Clinician and client will work collaboratively in the first 7 days of treatment to identify issues, develop goals and define interventions and strategies that will shape client's treatment episode. If there are safety concerns, these will be identified in the treatment plan with clear strategies and interventions outlined. These strategies and interventions will be clearly documented in the client's chart as well as communicated to staff both verbally and electronically via email. Safety concerns and corresponding strategies and interventions will be continually assessed and addressed daily. Clinicians and staff meet formally at a minimum of three times weekly in clinical meetings. Relevant information, including safety concerns and strategies and interventions to manage these, around clients is also shared electronically via email with all staff on a daily basis.

When an Incident Report for unsafe behavior (SI,

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V 112	Continued From page 9 SH, Elopement) is created the unsafe behavior will be added to the clients Treatment Plan by their primary therapist as soon as possible. If the behavior is already identified on their treatment plan the strategies and interventions will be reviewed and expanded if necessary. This addition will include an identification of the concerning behavior and a list of strategies to address and support the client in reducing and eliminating the behavior. These strategies will then be shared with all staff working with the client via email. Clinical Director [name] reviews all Treatment plans and will review all revisions made to them as a result of an Incident Report. She will ensure that the identified issue and strategies added to the clients' Treatment Plan are sufficient to support the client and that they are shared by the clinician with all staff via email. Describe your plans to make sure the above happens. As the Executive Director I review and sign off on IRs and participate in the meetings where client concerns and issues are reviewed can ensure that this plan is being utilized." Foothills at Red Oak Recovery is a 16 bed Supervised Living Facility for adolescent males with substance use disorders and co-occurring mental health diagnoses that include: Cannabis Abuse, Alcohol Use Disorder, Attention Deficit Hyperactivity Disorder (ADHD), and Major Depression. The facility serves clients that require intensive supervision, treatment, and structure to meet their complex needs as adolescents. Client #2 had a history of self-harming and suicidal thoughts and attempts.	V 112		

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V 112	Continued From page 10 Prior to admission he stabbed himself in the neck with a fork. Since his admission he self-harmed by scratching his arms and wrists at least 2 times in 7 days (5/5/21 and 5/10/21).. He disclosed suicidal thoughts such as wanting to drink a chemical agent. His treatment plan addressed self-harm and suicidal ideation within the problem of Depression on 6/2/21, almost a month after the client disclosed self-harming and his suicidal thoughts. The plan was to continue to assess his self-harm and suicidal ideation. The treatment plan did not provide any strategies to assist the client or the direct care staff with decreasing Client #2's urges to harm himself. Former Client #4 had a history of suicidal ideation and elopement. Within 39 days of admission he began to express suicidal ideations, 3 times in 25 days (2/15/21, 3/8/21 and 3/12/21). He first attempted to elope 39 days after admission (3/23/21). He had 5 additional attempts to elope until he was "therapeutically discharged." His treatment plan had the problem added of suicide ideation or self-harm 36 days after his first expression of wanting to kill himself. The plan did not include strategies to guide the client and assist the direct care staff in attempting to reduce the suicidal ideations and self-harm. Lack of treatment planning and providing strategies to address self-harm, suicidal ideations and elopement was determined to be 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 $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 112		

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V 118	Continued From page 11	V 118		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the 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:	V 118		

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V 118	Continued From page 12 Based on observation, record reviews, and interviews, the facility failed to have physician orders for administered medications; failed to administer medications as ordered by a physician, failed to keep the MARs current and failed to have physician orders to self-administer, affecting 3 of 3 audited clients (Clients #1, #2, and #3). The findings are: Review on 5/27/21 of Client#1's record revealed: -date of admission: 3/25/21 -diagnoses: Moderate Cannabis Use Disorder, Mild Alcohol Use Disorder, Generalized Anxiety Disorder, and Uncomplicated Bereavement; -age: 16 Review on 5/27/21, 6/1/21, 6/2/21, and 6/4/21 of MARs and Doctor's Orders for Client #1 revealed: -Lexapro 20 milligrams (mg), Take one tablet by mouth twice daily, ordered on 3/25/21 and signed on 6/4/21 ; -Focalin 30mg Extended Release (ER), Take one capsule by mouth, every morning, ordered 3/25/21 and not signed until 6/4/21; -Trazadone 50mg, Take one tablet by mouth every night at bedtime; ordered 3/29/21, signed on 6/4/21; -Keflex 500mg 1 tablet two times a day, for 7 days, ordered on 4/19/21, signed on 6/4/21; -Melatonin 3mg, take one tablet by mouth at bedtime as needed (PRN) ordered, 3/25/21; signed 6/4/21; -Bismuth Subsalicylate 262mg oral tab (Pepto Bismol), two tablets by mouth every 6 hours, PRN created on 4/5/21 and signed 6/4/21; Review on 5/27/21, 6/1/21, 6/2/21, and 6/4/21 of MARs for Client #1 revealed: -there were dashes in the MAR for Lexapro 20mg doses for 5/15/21 PM dose, 5/25/21 PM dose,	V 118		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 13 5/26/21 AM/PM dosages, 5/27/21 AM/PM dosages, and 5/31/21 PM Lexapro dose; -there were dashes in the MAR for Focalin 30mg ER morning dose for 5/15/21, 5/26/21, and 5/27/21; - 30mg Focalin ER since 3/25/21. -there were dashes in the MAR for Trazadone 50mg at bedtime for 5/20/21, 5/22/21, 5/25/21, 5/26/21, and 5/29/21; -Keflex 500mg appeared in the MAR as administered from 4/21/21 to 4/23/21 with an extra dose noted in the evening on 4/22/21 and 4/23/21 for a total of 3 days instead of the 7 days as ordered. -there was no explanation on the MAR for dash marks on the MARs. Review on 6/1/21 of email on 6/1/21 at 4:30pm from Corporate Compliance Officer to surveyors 1 & 2 revealed: -attached "Standing Orders" for Client #1's over the counter (OTC) medications were signed by the Physician's Assistant (PA) on 5/27/21; -she was working on getting the physician orders out of the system currently ..."there was a hang up with the PA and the system." -"all client medications are also addressed every time our PA meets with the clients ....any changes captured in his notes." -Compliance offered to send psychiatric progress notes for Client #1 which are "notes" referenced in this report. Review on 6/1/21 of Client #1's Psychiatric Progress Notes (Medication Evaluations) from 4/1/21 to 5/54/21 revealed: -Client #1's medications on 4/1/21 Psychiatric Progress Notes are listed as Focalin 50mg, every morning, Lexapro 20mg, twice a day, Trazadone 50mg every evening, and Melatonin as a	V 118		

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supplement; signed 4/1/21;
-Client #1's Focalin dosage on the Psychiatric Progress Notes on 4/22/21 was listed as Focalin 50mg ER, every morning (according to the MAR the client was given 30 mg).

Review on 5/27/21 of the electronic medical record for Client #1 revealed:
-medication orders appeared in electronic system for Client#1 , however surveyors could not locate signature of prescribing provider and requested them on 5/27/21 and 6/1/21;
-standing physician orders for OTC medications were signed at admission by the legal guardian and Registered Nurse or admissions counselor only.
-standing orders were provided on 6/1/21 and signed the day of the initial request (5/27/21).

Review on 5/27/21 of Client #2's record revealed:
-admitted 4/29/21.
-17 years old.
-diagnoses of Cannabis Use Disorder, severe; Major Depressive Disorder, severe, recurrent episode.

Review on 5/27/21 of the electronic record of "Physician Documents" for Client #2 revealed:
-the list of each medication with the Registered Nurses electronic signature and the date the medication was "created."
-under "status" for the physician it read "Review Signature."
-the physician had not signed any of the orders.
-medications listed were:
-Trazodone - 50 mg - 1/2 tablet at bedtime (created 5/7/21);
-Latuda - 80 mg - 1 tablet with dinner (created 4/29/21);
-Symbicort - 160-4.5 Micrograms (Mcg) inhaler -

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2 puffs, 2 times a day (created 4/29/21);
-Omeprazole (Prilosec) - 20 mg - 1 every day (created 4/29/21);
-Desvenlafaxin-E Succnt-ER (Pristiq) - 100 mg - 1 every day (created 4/2921);
-Melatonin - 3 mg - 1 at bedtime - as needed (PRN) (created 5/27/21);
-Albuterol HFA Inhaler - 1-2 puffs every 6 hours - PRN (created 4/29/21);
-Ibuprofen - 200 mg - 2 tablets every 6 hours - PRN (created 5/5/21).

Review on 5/27/21 of "Standing Orders for Over-The-Counter Medications" for Client #2 revealed:
-Melatonin - 3 mg - 1 at bedtime PRN
-Ibuprofen - 200 mg - 2 tablet every 6 hours - PRN.
-electronic signature by the PA 5/27/21.

Review on 5/27/21 of Psychiatric Progress Note dated 5/6/21 revealed:
-current medications:
-Trazodone - 25 mg - at bedtime;
-Latuda - 80 mg - at bedtime;
-Symbicort- 0.16 mg - 2 puffs, 2 times a day;
-Prilosec - 20 mg - every morning;
-Pristiq - 100 mg - every morning.
-Albuterol HFA Inhaler and Melatonin were not listed.
-there were no orders to self-administer any of the medications.
-electronic signature by the PA 5/6/21.

Review on 5/28/21 of the electronic record of Physician Orders for Client #2 revealed:
-signed 5/20/21 - Trazodone - increase to 50 mg at bedtime.
-signed 5/27/21 - Latuda - increase to 120 mg daily.

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V 118	Continued From page 16 Observation on 5/26/21 at 2:25 p.m. of Client #2's medications revealed: -Trazodone - 50 mg - 1/2 tablet at bedtime (increased to 50mg 5/20/21). -Latuda - 80 mg - 1 tablet daily with dinner. -Symbicort - 160-4.5 mcg - 2 puffs, 2 times a day. -Omeprazole - 20 mg - 1 every day. -Pristiq ER - 100 mg - 1 every day. Review on 5/28/21 of Client #2's electronic record of MARs for April and May 2020 revealed: -Trazodone - 50 mg - 1/2 tablet at bedtime - first dose given 5/13/21 (ordered 5/6/21); increase of 50 mg was not started until 5/27/21. -Latuda - 80 mg - 1 tablet with dinner - 5/21/21 through 5/23/21 was listed twice for 8:59 p.m. (totaling 160 mg) - both entries read "Taken" - 5/24/21-5/26/21 entries read "Hold." -Symbicort - 160-4.5 Mcg inhaler - 2 puffs, 2 times a day - refused 5/9 and 5/26- a.m. dose; blank 5/11 -p.m., 5/16- p.m., 5/27, 5/28, and 5/31- p.m. -Omeprazole (Prilosec) - 20 mg - 1 every day - refused 5/9 -Desvenlafaxin-E Succnt-ER (Pristiq) - 100 mg - 1 every day - refused 5/9 -Albuterol HFA Inhaler - 1-2 puffs every 6 hours - PRN - 5/27 "self-administered" -Ibuprofen - 200 mg - 2 tablets every 6 hours - PRN - 5/11 "self-administered" Review on 5/27/21 of Client #3's record revealed: -date of admission: 4/21/21 -diagnoses: Severe Cannabis Abuse Disorder -age: 16 Observation on 5/26/21 at 2:40 p.m. of Client#3's medications revealed: -Gabapentin 100mg, one capsule (cap) three	V 118		

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V 118	Continued From page 17 times daily (TID), dispensed 5/18/21; -Hydroxyzine 50mg cap, take one cap three times daily by mouth PRN; -Zoloft 50mg, take one tablet by mouth every morning; -Abilify 5mg, Take one tablet by mouth every night at bedtime dispensed 5/18/21; -Gabapentin 100mg, one cap twice daily dispensed 5/7/21. Review on 5/27/21, 6/1/21, 6/2/21, and 6/4/21 of Doctor's Orders for Client #3 revealed: -Gabapentin 100mg, one cap, twice a day, ordered 5/6/21 signed 6/4/21; -Gabapentin 100mg one cap, twice a day, ordered 5/10/21 signed 6/4/21; -Gabapentin 100mg one cap, three times a day, ordered 5/17/21, signed 6/4/21; -Gabapentin 300mg, take one tablet 2x day, ordered 5/20/21, signed 6/4/21; -Zoloft 50mg, take one tablet by mouth every morning ordered 4/21/21, signed 6/4/21 -Abilify 5mg, take one tablet by mouth every night, ordered 4/21/21, signed 6/4/21 -Hydroxyzine 50mg, take one caplet three times a day as needed, (PRN); ordered 4/21/21, signed 6/4/21; -Clindamycin 300mg, 2 caps, three times a day for 15 days, ordered on 4/21/21, signed on 6/4/21; -Melatonin 3mg, take one tablet, every night PRN, ordered 5/27/21, signed 6/4/21; -Zyrtec 10mg, take one tablet daily PRN, ordered: 4/28/21, signed 6/4/21. -"hold" for Abilify on 4/29/21, note said given in AM and scheduled for 9pm at night; Review on 5/27/21, 6/1/21, 6/2/21, and 6/4/21 of MARs for Client #3 revealed: -there were dashes in MAR for Abilify 5 mg for	V 118		

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dosages on 5/7/21, 5/29/21, and 5/30/21;
-there were dashes in MAR for Gabapentin dosages on 5/11/21, 5/23/21 midday, 5/24/21 midday, 5/25/21 midday, 5/27/21 PM dose, 5/28/21 PM dose, 5/31/21 dose;
-Gabapentin increased to 100mg 3x day on 5/17/21 and shows up in MAR on 5/20/21
-Gabapentin increased to 300mg 2x day on 5/20/21 and doesn't show up in MAR until 5/27/21
- Client#3 had been taking 50mg Hydroxyzine, PRN up to three times a day (not 100mg BID).

Review on 6/1/21 of email on 6/1/21 at 4:30pm from Corporate Compliance Officer to surveyors 1 & 2 revealed:
-attached "Standing Orders" for Client #3's OTC medications were signed by the Physician's PA on 5/27/21;
-she was working on getting the physician orders out of the system currently ..."there was a hang up with the PA and the system."
-"all client medications are also addressed every time our PA meets with the clients ....any changes captured in his notes."
-Compliance offered to send psychiatric progress notes for Client #3 which are "notes" referenced in this report.

Review on 6/1/21 of Client #3's Psychiatric Progress Notes (Medication Evaluations) from 4/26/21 to 5/24/21 revealed:
-Client #1's medications on 4/26/21 Psychiatric Progress Notes are listed as Hydroxyzine 100mg, every day (PRN), Abilify 5mg, every evening, Zoloft 50mg, every day, Clindamycin 300mg 2caps three times a day signed 4/26/21;
-4/29/21, Hydroxyzine 100mg BID, QD ordered 4/29/21 and signed 4/29/21;
-Hydroxyzine dosage never changed in notes after this;

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V 118	Continued From page 19 -Gabapentin 100mg, twice a day, (BID) ordered on 5/6/21, signed 5/6/21; -Gabapentin 100mg BID ordered 5/10/21, signed 5/10/21; -Gabapentin 100mg TID ordered 5/17/21, signed 5/17/21; -Gabapentin take one tablet 2x day ordered 5/20/21 signed 5/20/21; Observation on 5/26/21 at 11:10 a.m. of medication cart at the facility revealed; -OTC and as needed PRN medications were observed in the cart for clients including: Pepto-Bismol, Melatonin, Ibuprofen, MiraLAX, Benadryl, and Zyrtec. Review on 5/27/21 of the electronic medical record for Client #3 revealed: -medication orders appeared in electronic system for Client #3, however surveyors could not locate signature of prescribing provider and requested them on 5/27/21 and 6/1/21; -standing physician orders for OTC medications were signed at admission on 4/20/21 by the legal guardian and Registered Nurse or admissions counselor only. -standing orders were provided on 6/1/21 and signed the day of the initial request (5/27/21). Interview on 5/26/21 and 6/1/21 with Clients #1-3 revealed: -all three clients reported that they got their medications. Interview on 6/2/21 and 6/7/21 with Registered Nurse revealed: -he knew standing orders for OTC medications had to be signed by a doctor ...he believed those orders were taken care of at admission; -Client #3 had always taken 50mg of Vistaril PRN	V 118		

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V 118	Continued From page 20 and that had not changed; -Client #1 had always taken 30mg ER Focalin; -when asked to explain a dash in the electronic MAR on 5/7/21 for Client #3 he reported not being able to answer to that...he saw what surveyors saw; -"If there is a dash, I can't speak to that" -"if there is a refusal with a medication ... there should be a note in the MAR and an incident report filled out;" -regarding Client #3's missing dates for Keflex prescription, he saw what the surveyor saw on the MAR ..."[Client #3] got his medication ...it's an issue with the system." -he also saw on the MAR where Client #2 appeared to get double doses of Latuda for 3 days and then it was held for 3 days - he was not sure what happened. -there was "no way" Client #2 got two doses of Latuda because he would have ran out, and he knows he didn't run out. -the staff probably put it on hold because it was listed twice and they didn't know what else to do. -he looked for notes in the electronic MAR to explain the Latuda, but there were none. -they sent paper MARs with staff when clients went on off-campus trips; -Client #1 was gone off campus on a camping trip from 5/25/21-5/27/21; -surveyors requested paper copies of MARs for dates Client#1 was off campus; -none of the clients self-administered medications - if it was a PRN - that was the only option the system would allow staff to input - "self-administered." -clients saw the PA one time a week, the provider reached out to guardians for consent and then puts the orders in the system, "sometimes it takes, sometimes it doesn't ....they've been working on getting the hole in the system fixed."	V 118		

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V 118	Continued From page 21 -the facility had "been struggling to get orders signed timely, finally it got fixed;" -he started new orders on Thursdays ...and was able to keep track by the provider's emails or seeing him in person; By the time of exit on 6/11/21 the surveyors had not received copies of paper MARs for Client #1. Review on 6/1/21 of facility's written policies regarding medication revealed; -"Foothills at Red Oak Recovery, LLC holds a Standing Order for Over-the-Counter Medications by the provider physician." Due to the failure to accurately document medication administration it could not be determined if clients received medications as ordered. Review on 6/8/21 of the first plan of protection written by the Executive Director dated 6/8/21 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? 1.Starting with medication administration on 6/8/21, Executive Director (ED) will review the Electronic Medical Record (EMR) to ensure that each client's chart has been updated to reflect whether they received their medications. In situation where medications were not administered, ED will review the EMR to ensure that an Incident Report (IR) has been completed detailing the reasons that a medication was not administered. A checklist for review will be completed each day for each (checklist attached). 2. On 6/8/21 Compliance Officer [Compliance	V 118		

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V 118	Continued From page 22 Officer] will review the EMR to ensure it is working properly in recording when medications are administered. The EMR medication administration section will be adjusted to require the question of whether a medication was administered to be answered before moving on in the system. 3. [Compliance Officer] has already created an audit function in the EMR to check to ensure that all prescribers' orders are signed. This will be conducted weekly and will included that all prescribers' orders are signed and that the information is consistent between the orders the MAR and the prescription label. ED will conduct these audits 4. The Medical Services staff [medical services staff] will assume the responsibility for the daily reviews and weekly audits starting on 6/14/21. 5. All staff who administer medication will be required to complete retraining in medication administration by 6/10/21. Describe your plans to make sure the above happens. As the Executive Director I will be doing the initial reviews and once medical services staff begins in her role as Medical Services Staff I will ensure the responsibility is explained and transferred to her. I have spoken to Compliance Officer and will be working with her to ensure any issues with the EMR are remedied. I [Executive Director] will also be attending the retraining of staff and will ensure that staff attendance and training completion is documented." Review on 6/8/21 of Amended Plan of Protection	V 118		

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V 118	Continued From page 23 written by the Executive Director dated 6/8/21 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? 1.Starting with medication administration on 6/8/21, Executive Director (ED) will review the Electronic Medical Record (EMR) to ensure that each client's chart has been updated to reflect whether they received their medications. In situation where medications were not administered, ED will review the EMR to ensure that an Incident Report (IR) has been completed detailing the reasons that a medication was not administered. A checklist for review will be completed each day for each (checklist attached). 2. On 6/8/21 Compliance Officer [Compliance Officer] will review the EMR to ensure it is working properly in recording when medications are administered. The EMR medication administration section will be adjusted to require the question of whether a medication was administered to be answered before moving on in the system. 3. Compliance officer has already created an audit function in the EMR to check to ensure that all prescribers' orders are signed. This will be conducted weekly and will included that all prescribers' orders are signed and that the information is consistent between the orders the MAR and the prescription label. ED will conduct these audits 4. The Medical Services staff [medical services staff] will assume the responsibility for the daily reviews and weekly audits starting on 6/14/21.	V 118		

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V 118	Continued From page 24 5. All staff who administer medication will be required to complete retraining in medication administration by 6/10/21. Retraining to begin on 6/8/21. Only staff who have completed the retraining will be allowed to administer medication. Describe your plans to make sure the above happens. As the Executive Director I will be doing the initial reviews and once Medical Services Staff begins in her role as Medical Services Staff will ensure the responsibility is explained and transferred to her. I have spoken to Compliance Officer and will be working with her to ensure any issues with the EMR are remedied. I [Executive Director] will also be attending the retraining of staff and will ensure that staff attendance and training completion is documented." Foothills at Red Oak Recovery is a 16 bed Supervised Living Facility for adolescent males with substance use disorders and co-occurring mental health diagnoses that include: Cannabis Abuse, Alcohol Use Disorder, Attention Deficit Hyperactivity Disorder (ADHD), and Major Depression. The facility serves clients that require intensive supervision, treatment, and structure to meet their complex needs as adolescents. Medications were not administered as ordered by a physician as evidenced by differences in medication orders and MAR instructions. The MARs were not accurate for all 3 clients sampled. Standing orders for over the counter medications were not signed by a physician at admission dates. OTC and PRN medications were "self-administered" without physician orders to do so. Client #1 had 15 errors in the MAR in a three month period. Client	V 118		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 25 #2 had two medications that started a week after ordered and one medication that was listed twice as taken thus potentially a double dose in 3 days. There were refusals and blanks or dashes in the MARs with no explanation. Client #3 had 11 errors in the MAR in a 35 day time period. These are medications used to treat ADHD, Anxiety, Depression, mood stabilization, aggression/agitation, and sleeplessness. The inability to determine if clients received their medications as ordered was found to be 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 $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th 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 review and interview, the facility failed to access the Health Care Personnel	V 131		

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V 131	Continued From page 26 Registry (HCPR) prior to hiring 2 of 6 audited staff (Therapist #2 and Staff#2). The findings are: Review on 5/28/21 and 6/2/21 of Therapist #2's record revealed: -date of hire: 8/5/20; -date of HCPR check: 08/10/20 Review on 5/28/21 of Staff #2's record revealed: -date of hire: 3/11/19 -date of HCPR check: 3/15/19 Interview on 6/10/21 with Corporate Compliance Officer revealed: -she was unaware that this had occurred; -she will make sure this gets taken care of moving forward. This deficiency constitutes a recited deficiency and must be corrected within 30 days.	V 131		
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;	V 366		

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V 366	Continued From page 27 (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 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	V 366		

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V 366	Continued From page 28 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 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.	V 366		

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V 366	Continued From page 29	V 366		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to document their response to level II incidents and failed to implement written policies governing their response to level I and level II incidents involving 2 of 2 Former Clients (FC #1 and #2). The findings are:

Review on 6/8/21 of FC#1's record revealed:
-date of admission: 02/11/21
-date of discharge: 04/14/21
-diagnosis: Severe Alcohol Use Disorder
-age: 17

Review on 6/4/21 of facility incident reports from 3/1/21 to 5/26/21 revealed:
-an incident on 3/8/21 in which there was a verbal altercation between an overnight awake staff and FC#1 in which facility staff became verbally escalated towards FC#1 and refused to leave;
-facility staff had to intervene to de-escalate the situation and remove FC#1 from the situation;
-there was no documented follow up on the incident report other than a work order for maintenance completed;
-there was no supervisor signature on the incident report where it shows that the incident had been reviewed;
-there was no documented notification to the Guardian/Local Managing Entity (LME) from incident.

Interview on 5/28/21 with Human Resources Manager revealed:

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V 366	Continued From page 30 -the incident in March 2021 with overnight awake staff and client, "staff quit immediately ...it was reported by the former program director who is no longer here." Interview on 6/8/21 with FC#1's guardian revealed: -she was aware of incident with overnight awake staff and "understood words were said ...and the staff person was fired." Review on 5/28/21 of FC #2's record revealed: -admitted 1/6/21. -17 years old. -diagnoses of Cannabis Use Disorder, severe; Alcohol Use Disorder, moderate; Parent-Child Relational Problem, mild; Major Depressive Disorder, recurrent episode, with mixed features. -4/1/21 - "Therapeutic Discharge" Review on 6/4/21 of a statement dated 2/25/21 at approximately 6:00 p.m. entitled "Incident with [FC #2]" and signed by Former Staff (FS) #3 revealed: -the client ran from his bedroom to outside the facility. -three staff members followed the client as he began sprinting down the driveway. -FS #1 wrapped his arms around the client and both fell to the ground. -FS #1 held him on the ground for a few seconds. -client was laying on the ground crying and screaming. -he got up and appeared to be heading back to facility when he darted away behind the facility and towards the tree line. -FS #1 tried to wrap his arms around him again and they both fell to the ground again. -client was on the ground again screaming and cursing.	V 366		

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V 366	Continued From page 31 -FS #1 continued to hold the client on the ground in a "bear hug." -the client de-escalated and agreed to walk back to the house. Review on 6/4/21 of facility incident reports from February 2021 revealed: -there was no incident report for FC #2 dated 2/25/21. Review on 5/28/21 of FS #1's Employee Improvement Plan dated 2/25/21 revealed: -final warning - failed to complete incident report after physical restraint. -plan was to complete "Safety Care" (Restrictive Intervention Training) and incident report training. Review on 5/28/21 of FS #1's employee file revealed; -he resigned 3/11/21. -his "Safety Care" training expired 2/6/21. Interview on 5/28/21 with the Human Resources Manager revealed: -he found out about the incident with FC #2 via an email from FS #3. -an incident report was not done. -the shift supervisor should have immediately reported the incident and have FS #1 do an incident report. -the failure to ensure an incident report was completed was the reason the shift supervisor was terminated. -they planned to re-train FS #1 but he resigned before they were able to. -FS #3 had not received "Safety Care" training yet and should not have been involved with the incident - however it was determined she did not have physical contact with the client.	V 366		

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V 366	Continued From page 32 Review on 6/1/21 of facility's policy on reporting incidences dated 01/02/2019 revealed: -"Foothills at Red Oak Recovery, LLC will use the NC DHHS Critical Incident Reporting Form for any level 2, 3 and 4 incidents ...Foothills at Red Oak Recovery, LLC will also conduct a root cause analysis and thorough debrief surrounding any serious incidents within 72 hours or less." Interview with Executive Director on 6/9/21 revealed: -he thought that the facility incident reports should be "more robust" -he has had to go back and review incidents that should have been reviewed by the former program director who was employed during the referenced incident in March.	V 366		
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 property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal	V 536		

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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; and
(9) positive behavioral supports (providing means for people with disabilities to choose

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V 536	Continued From page 34 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; (C) methods for evaluating trainee performance; and (D) documentation procedures.	V 536		

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V 536	Continued From page 35 (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. This Rule is not met as evidenced by:	V 536		

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V 536	Continued From page 36 Based on record review and interviews, the facility failed to ensure that all staff completed training and received updated training in alternatives to restrictive intervention prior to providing services for 1 of 3 Former Staff (FS) audited (FS #1, and FS#3). The findings are: Review on 5/28/21 of FS #1's employee file revealed; -he resigned 3/11/21. -his "Safety Care" training expired 2/6/21. Review on 5/28/21 of FS#3's record revealed: -date of hire: 12/21/20 -date of approved training on alternatives to restrictive interventions: 3/13/21, attendance and test only; -date of separation: 5/25/21. Review of a statement dated 2/25/21 at approximately 6:00 p.m. entitled "Incident with [Former Client #2]" and signed by FS #3 revealed: -FS #1 wrapped his arms around the client on 2 occasions and on each occasion they both fell to the ground. -FS #1 held FC #2 on the ground both times after they fell. Interview on 6/9/11 with FS#3 revealed: -in her role she provided group and individual therapy during the week; -she was trained in Safety Care ..."one to two months before I left ...;" -she was hanging out with the kids when the incident happened with FC#2 in February 2021; -she was present when FC#2 tried to elope from facility and another staff tried to put FC#2 in a therapeutic hold; -she confirmed she was not Safety Care trained	V 536		

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V 536	Continued From page 37 when this incident occurred. Interview on 5/28/21 with Human Resources Manager revealed: -FS#3 "started directly on campus ...and then did on-board training ...sometimes with shortages we have them start on campus;" -"...typically, new staff start at the facility office and complete HR paperwork, initial clinical training, first aid/CPR and then they start Safety Care [Restrictive Intervention Training]." -they planned to re-train FS #1 due to the incident on 2/25/21 where he restrained a client by himself. -FS #1 resigned before they were able to re-train him. -FS #3 had not received "Safety Care" training yet and should not have been involved with the 2/25/21 incident - however it was determined she did not have physical contact with the client.	V 536		