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V 000	INITIAL COMMENTS A complaint, follow-up and annual survey was completed on June 15, 2021. The complaint was substantiated (Intake #NC00177579). This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying,	V 108		

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V 108	Continued From page 1 reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure that all staff were trained in an approved Cardiopulmonary Resuscitation (CPR) and First Aid course for 1 of 9 audited staff (Staff #2). The findings are: Review on 6/11/21 of Staff #2's personnel file revealed the following information: -- Date of hire 1/12/14. -- Paraprofessional. -- Direct care staff. -- A CPR/First Aid certificate from an on-line course dated 10/26/19. Interview on 6/15/21 with the Licensee/Facility Director revealed the following information; -- She was unaware that on-line First Aid and CPR courses are not accepted by DHSR (Division of Health Service Regulation) as approved training. **Note: This facility is licensed as a 1700; Residential Treatment Staff Secure for Children or Adolescents and at any time a client is present (unless otherwise specified in a treatment plan) at least 2 staff must be on duty. Refer to tag V-296, Minimum Staffing for additional details.**	V 108		

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V 111	Continued From page 2	V 111		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented. This Rule is not met as evidenced by:	V 111		

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V 111	Continued From page 3 Based on interview and record review, the facility failed to assure an assessment was completed for each client prior to the delivery of services affecting 2 of 2 audited current clients (#1 #2) and 2 of 2 former clients (FC #4 FC #5). The findings are: Review on 6/4/21 of Client #1's record revealed the following information: -- A 16-year-old female. -- Date of admission to the facility: 8/28/20. -- Diagnoses include Major Depressive Disorder-Unspecified, Unspecified Disruptive Impulse Control and Conduct Disorder, ODD (Oppositional Defiant Disorder)-Moderate, ADHD (Attention Deficit Hyperactivity Disorder) -Predominantly Hyperactive Impulsive Presentation, Generalized Anxiety Disorder, Panic Attacks, Psychosis - NOS (not otherwise specified), History of self-harm, Parent - child relational problems and Asthma. -- Psychological testing dated 12/17/20: "FSIQ (Full Scale Intelligence Quotient) = 80 - low average." -- "Does the member (Client #1) have a history of being neglected, or physically, emotionally or sexually abused? Yes." -- No documentation of a presenting problem or identified strategies to meet the client's presenting needs. Review on 6/7/21 of Client #2's record revealed the following information: -- A 15 year old female. -- Admitted to the facility on 12/5/20. -- Diagnoses include Major Depressive Disorder, Anxiety and ODD. -- No documentation of a presenting problem or identified strategies to meet the client's presenting needs.	V 111		

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V 111	Continued From page 4 Review on 6/3/21 and 6/4/21 of FC #4's record revealed the following information; -- A 16-year-old female. -- Date of admission to the facility: 11/5/20. -- Date of discharge: unknown (no Discharge Summary completed). -- Transported to the hospital by staff on 5/28/21 for a psychiatric evaluation and did not return to the facility. -- Diagnoses include Major Depressive Disorder, Disruptive Mood Dysregulation Disorder, PTSD (Post Traumatic Stress Disorder), ADHD and Oppositional Defiant Disorder. -- She came to this the group home from a PRTF (Psychiatric Residential Treatment Facility - provides non-acute inpatient facility care for adolescents who do not meet criteria for acute inpatient care, but do require supervision and specialized interventions on a 24-hour basis). -- No documentation of a presenting problem or identified strategies to meet the client's presenting needs. Review on 6/11/21 of FC #5's record revealed the following information: -- A 17 year old female. -- Was admitted to the facility on 5/5/21, and discharged on 5/11/21 (total of 7 days). -- Has an appointed county DSS (Department of Social Services) guardian. -- Diagnoses include Bipolar Disorder, ADHD, ODD and Borderline Personality Disorder. -- No documentation of a presenting problem or identified strategies to meet the client's presenting needs. -- A "Client Emergency Information" form dated 5/56/21 documenting the following: "Client has a broken left wrist... Child has a history of cutting, none current... Presenting Problems: No	V 111		

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V 111	Continued From page 5 concerns" -- No documentation of a presenting problem or identified strategies to meet the client's presenting needs. Interview on 6/7/21 with the Licensee/Facility Director revealed the following information; -- She confirmed that there was not a form used by the facility for an admission assessment. -- Staff gathered some of the required information about the clients and documented this on various other forms in the record. This deficiency is cross referenced into 10A NCAC 27G .1701 SCOPE (V-293) for a Type A1 rule violation and must be corrected within 23 days.	V 111		
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	V 112		

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V 112	Continued From page 6 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 interview and record review, the facility failed to develop and implement strategies and interventions within a treatment plan to address behaviors of elopement, sexualized behaviors and self injury affecting 1 of 2 former clients (FC #4). The findings are: A. Review on 6/3/21 and 6/4/21 of FC #4's record revealed the following information -- A 16-year-old female. -- Date of admission to the facility: 11/5/20. -- Date of discharge: unknown (no Discharge Summary completed). -- Transported to the hospital by staff on 5/28/21 for a psychiatric evaluation. -- Diagnoses include Major Depressive Disorder, Disruptive Mood Dysregulation Disorder, PTSD (Post Traumatic Stress Disorder), ADHD (Attention Deficit Hyperactivity Disorder) and Oppositional Defiant Disorder. -- She came to this the group home from a PRTF (Psychiatric Residential Treatment Facility - provides non-acute inpatient facility care for adolescents who do not meet criteria for acute inpatient care, but do require supervision and	V 112		

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V 112	Continued From page 7 specialized interventions on a 24-hour basis). Review on 6/4/21 of FC #4's record revealed the following information: A treatment plan dated 9/25/20, updated on 10/16/20 (both dates prior to her admission to this facility) written by the PRTF the client came from revealed the following information: -- "Will participate in recreational therapy activities (a recreational therapy goal initiated by the PRTF the client came from and not applicable to this facility)." -- A sleep goal - Savin Grace group home is listed as a person/entity responsible, however there are no interventions/strategies identified for the group home staff. -- Education goal - Savin Grace group home is listed as a person/entity responsible, however there are no interventions/strategies identified for the group home staff. -- Medication Management - Savin Grace group home is listed as a person/entity responsible, however there are no interventions/strategies identified for the group home staff. -- "Treatment History: Per Admission Psychiatric Evaluation: ...presents to [name of PRTF she was at prior to admission to Savin Grace II] due to increasing risk taking and impulsive behaviors which have been difficult to manage at lower levels of care. She was recently admitted to another PRTF for 1 year due to frequent elopement from home as well as frequent SIB (self-injurious behavior) behaviors and was discharged in June of 2020. She reportedly quickly decompensated and was actually hospitalized 3 times upon returning home and attempting intensive in-home services. Today on interview she reports that she came here today from [name of Psychiatric hospital] where she reports she had been for the past 50 days. She	V 112		

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reports that the hospitalization was due to her repeated running away from home which she reports is her primary issue. She reports that she runs away when feeling 'bored' and 'to have fun with friends' and reports that she is typically gone for 4 - 5 days ...Her guardian (adoptive mother) reports that she has had to file police reports numerous times due to [FC #4's] behaviors and reports that she is no longer manageable at home ..."
-- Savin Grace did not update FC #4's previous treatment plan to address behaviors of elopement, sexualized behaviors and self injury.

Review on 6/11/21 of "Monthly Progress Reports" for FC #4 revealed the following information;
November 2020:
11/12/20 - "Ran away during the night"
11/13/20 - "AWOL (away with out leave)"
11/14/20 - "Absent"
11/15/20 - "In the hospital"
11/16/20 - "We arrived back (to the facility) @ 5:00 ..."

January 2021:
1/8/21 - "AWOL"
1/9/21 - "AWOL"

March 2021:
3/3/21 - "Ran away from facility"
3/4/21 - "AWOL - returned back to facility @ 9:20 pm"

April 2021:
4/21/21 - 4/30/21 - "AWOL"

May 2021:
5/1/21 - 5/4/21 - "AWOL - Runaway status"
5/5/21 - 5/10/21 - "AWOL"
5/11/21 - "Returned back to facility in not a good

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state (gone 4/21/21 through 5/11/21 = 20 days)"
5/22/21 - 5/23/21 - "Runaway status"
5/24/21 - "AWOL - Runaway status"
5/25/21 - 5/26/21 - "AWOL"
5/28/21 - "Went to get behavioral assessment"
5/29/21 - 5/31/21 - "Hospitalized"

The above information confirms FC #4 was admitted to the facility for approximately 7 months. During this time she was gone without authorization as follows: Nov. 2020 = 5 days, Jan. 2021 = 2 days, March 2021 = 2 days, April/May 2021 = 20 days and May 2021 = 5 days.
This represents the client's total time away from facility = 35 days.

Review on 6/14/21 of documents titled "Savin Grace Monthly Summary" for FC #4 revealed the following information;
-- 11/5/20 - 12/09/20:
"[FC #4] ran away 11/12 (2020) and returned back to the facility on 11/16 (2020)."
-- No "Monthly Summary" for 12/10/20-1/9/21 provided for review.
-- 1/10/21 - 2/10/21:
"How has the patient shown progress since she has been in the facility? ...[FC #4] has run away from the facility once but has not tried again ..."
"What do you see as the most significant behavioral/emotional problem for this member right now? That [FC #4] still has running away in the back of her mind."
-- 2/11/21 - 3/10/21:
"How has the patient shown progress since she has been in the facility? [FC #4] has shown very little progress since being in the facility... [FC #4] has ran away from the facility again during the last 30 days."
"What do you see as their most significant behavior/emotional problems for this member

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right now? That [FC #4] still has running away in the back of her mind. [FC #4] is not able to stay in one place to long. [FC #4] likes to be on the go and can not do that being in the facility."
-- 3/12/21 - 4/11/21: No information documented.
-- 4/12/21 - 5/12/21:
"What do you see as the most significant behavior/emotional problems for this member right now? That [FC #4] still has running away in the back of her mind."

Review on 6/14/21 of the "Staff Communication Log" revealed the following information;
-- 4/21/21 - "Came back to the facility (from therapeutic leave) and ran away."
-- 5/11/21 - "Returned back to the facility in not a good state."
-- 5/12/21 - "Good day slept all day."

Review on 6/4/21 of FC #4's record revealed she received a medical evaluation following her return to the facility on 5/14/21 (two days later).

Review on 6/14/21 of FC #4's record revealed the following information;
-- A Weekly Therapy note dated 1/8/21 "Client ran away via her room window around 5 am the morning of 1/8/21." "The client was located by the police on 1/10/21 and taken to the hospital for a pregnancy test ..."

Interview on 6/4/21 with FC #4's Adoptive Mother revealed the following information;
-- "[FC #4] left the group home 6 or 7 times, she was gone for 40 to 45 days."
-- The facility "had only 1 staff on duty about 90 % of the time."
-- "She (FC #4) went to different places when she left (the group home)."
-- "(FC #4) was infatuated with gangs."

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V 112	Continued From page 11 -- "I saw her doing gang signs." -- Before she would leave the facility, "she would call people to come pick her up or call for an Uber ride." -- "She is not supposed to have a cell phone while in the group home." -- "She must be getting cell phones from the people who come and get her." -- "She called me one time in February or March and asked me if I could come and and pick her up, that she was cold. It was 28 degrees outside, she was at (name of a large chain store) in (a nearby town - about 25 miles away)." -- Staff #1 "called me (January 8, 2021) and she said she just woke up and [FC #4] was gone." -- "When she (FC #4) came back to the group home on May 11, 2021, I got a call from staff asking what are you going to do with her? We already admitted someone else." -- When she was gone in March/April 2020 (the longest time FC #4 was missing, for 20 days) "she told me she had been in a prostitution ring." Interview on 6/4/21 with Client #1 revealed the following information: -- FC #4 ran away "about 6 or 7 times." -- She "asked me to go with her but I told her no." Interview on 6/4/21 with Client #2 revealed the following information: -- FC #4 ran away "about 4 times." -- "She asked me if I wanted to go, but I didn't go." Interview on 6/4/21 with Client #4 revealed the following information: -- FC #4 ran away "about 7 or 6 times." Interview with the Licensee/Facility Director on 6/11/21 revealed the following information;	V 112		

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V 112	Continued From page 12 -- She confirmed that FC #4 was away from the facility on the above occasions. -- She has been having a difficult time since the COVID-19 pandemic hiring new staff and retaining old staff. -- She does not have enough current staff to cover all of the shifts needing covered. -- She offered no more information about how the facility was addressing FC #4's running behaviors. This deficiency is cross referenced into 10A NCAC 27G .1701 SCOPE (V-293) for a Type A1 rule violation and must be corrected within 23 days.	V 112		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name;	V 118		

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V 118	Continued From page 13 (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 interview and record review, the facility failed to assure a) medications were administered on the written order of a Physician, b) all MARs were kept current and c) staff demonstrated competence in medication documentation and administration affecting 1 of 2 current audited clients (#2) and 2 of 2 former clients (FC #4 FC #5). The findings are: 1. Review on 6/7/21 of Client #2's record revealed the following information: -- A 15 year old female. -- Admitted to the facility on 12/5/20. -- Diagnoses include Major Depressive Disorder, Anxiety and ODD (Oppositional Defiant Disorder). Review on 6/11/21 of Client #2's record revealed the following Physician's order: -- A prescription dated 4/28/21 for Keflex (an Antibiotic) 500 mg. (milligrams) three times a day for 7 days. Review on 6/11/21 of Client #2's MARs revealed	V 118		

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V 118	Continued From page 14 the following information: -- April 2021 MAR: no transcription for or documentation that any of this medication was administered to the client on 4/29/21 or 4/30/21 (total of 6 doses, 2 of the 7 days). -- May 2021 MAR: a transcription for Keflex 500 mg. to be administered three times a day. No documentation of administration on these dates/times: 5/1/21 (all 3 doses), 5/2/21 (8 am and 4 pm doses), 5/3/21 (4 pm dose), 5/4/21 (4 pm dose and 8 pm dose) and 5/5/21 (4 pm dose) (total of 9 doses, the remainder of the 7 days). The above information reflects this antibiotic therapy for Client #2 was not initiated until 2 days after the Physician wrote a prescription for it. 2. Review on 6/3/21 and 6/4/21 of FC #4's record revealed the following information: -- A 16-year-old female. -- Date of admission to the facility: 11/5/20. -- Date of discharge: unknown (no Discharge Summary completed). -- Transported to the hospital by staff on 5/28/21 for a psychiatric evaluation. -- Diagnoses include Major Depressive Disorder, Disruptive Mood Dysregulation Disorder, PTSD (Post Traumatic Stress Disorder), ADHD (Attention Deficit Hyperactivity Disorder) and ODD. Disorder. a. Interview on 6/4/21 with Staff #1 revealed the following information: -- FC #4 used to have a hard time sleeping. -- The staff would give her Melatonin to help her sleep. -- She confirmed that FC #4 did not have a Physician's order for Melatonin. -- She was unaware that even over-the-counter medications for administration to clients required	V 118		

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V 118	Continued From page 15 a Physician's order. b. Review on 6/4/21 of FC #4's record revealed the following information: -- A Physician's order from an Emergency Room dated 5/14/21 for Omnicef 300 mg. twice a day for 10 days. -- A May 2021 MAR with no transcription for or documentation that this medication was administered (this clients last day in the facility - 5/27/21). c. Review on 6/4/21 of the "Staff Communication Log" revealed the following information regarding FC #4: -- 3/4/21 - "AWOL - returned back to facility @ 9:20 pm" -- 3/6/21 - " ...taken to hospital (for a medical evaluation 2 days following her return to the facility)." Review on 6/4/21 of FC #4's record and March 2021 MAR revealed the following information: -- A Physician's order dated 3/6/21 for Macrobid 100 mg. twice a day for 7 days (an Antibiotic). -- On the March 2021 MAR staff initials circled on 3/7, 3/8 and 3/9/21 (for the PM dose, no documentation of administration of the AM dose on 3/7, 3/8 or 3/9/21 - Staff initials circled means the medication was not given). -- The first dose of this medication was administered to the client on 3/10/21 in the morning (4 days after the date of the prescription, and 6 days after her return to the facility). d. Review on 6/4/21 of FC #4's record revealed the following information: -- A note from a Physician at an Emergency Room (ER) dated 11/19/20 with the following information: "Seen for: Vaginal Itching. DX	V 118		

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(diagnosis): Potential exposure to STD (Sexually Transmitted Disease), genital itching. Given Zithromax and Rocephin (both Antibiotics)."
-- A staff note dated 11/19/20 "went to the hospital today to get tested for STDs since she engaged in unprotected risky behaviors while she was away from the group home."
-- A note and prescription 11/19/20 from an Emergency Room Physician as follows: "Exposure to STD. DX: Symptom associated with female genital organs, Yeast Infection. Diflucan 100 mg. daily for 14 days (an Antibiotic)."
-- A November 2020 MAR with no transcription for or documentation that this medication was administered.
-- A December 2020 MAR with a transcription for Diflucan 100 mg. daily for 14 days and documentation that it was administered on 12/1/20, 12/3/20 and 12/4/20.

Review on 6/3/21 and 6/4/21 of FC #4's record revealed the following delays in obtaining medical treatment and therefore administration of prescribed medications:
-- FC #4 returned to the facility (after elopement) on 11/16/20. She was medically evaluated on 11/19/20.
-- FC #4 returned to the facility (after elopement) on 3/4/21. She was medically evaluated on 3/6/21.
-- FC #4 returned to the facility (after elopement) on 5/11/21. She was medically evaluated on 5/14/21.

3. Review on 6/11/21 of FC #5's record revealed the following information:
-- A 17 year old female.
-- Was admitted to the facility on 5/5/21, and discharged on 5/11/21 (total of 7 days).
-- Diagnoses include Bipolar Disorder, ADHD,

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V 118	Continued From page 17 ODD and Borderline Personality Disorder. Review on 6/11/21 of FC #5's record revealed the following information: -- A Physician's order dated 3/2/21 for Zoloft 50 mg. every evening. -- No documentation of a Physician's order for Vyvanse 40 mg. every morning. Review on 6/11/21 of FC #5's May 2021 MAR revealed the following information: -- A transcription for Zoloft 50 mg. every evening. -- No documentation indicating the client was administered this medication on 5/7/21. -- A transcription for Vyvanse 40 mg. every morning. -- No documentation indicating the client was administered this medication on 5/6/21. 4. Review on 6/11/21 of Staff #7's personnel file revealed the following information: -- Date of hire 3/21/21. -- Paraprofessional. -- No documentation of any training in Medication Administration. Review on 6/11/21 of the "Staff Communication Log" revealed the following times when Staff #7 worked in the facility alone: -- 6/1/21 - 8 am to 8 pm. -- 6/11/21 - 8 pm to 8 am. -- 6/12/21 - 8 am to 8 pm. Interview on 6/3/21 with the Qualified Professional (QP) revealed the following information: -- It was not her responsibility to oversee client medications. -- She was not sure who was responsible for that aspect of client care/treatment.	V 118		

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V 118	Continued From page 18 Interview on 6/7/21 with the Licensee/Facility Director revealed the following information: -- Since the former QP left her position, no one has really had oversight of medication administration. -- She had no explanation for the delay in beginning antibiotic therapy for the 2 clients identified. Due to the failure of staff to accurately document medication administration, it could not be determined if clients received medications as ordered by their Physicians. This deficiency is cross referenced into 10A NCAC 27G .1701 SCOPE (V-293) for a Type A1 rule violation and must be corrected within 23 days.	V 118		
V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of	V 120		

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V 120	Continued From page 19 controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure that all medications were stored in a securely locked space affecting 2 of 2 current audited clients (#1 #2) and 2 of 2 current unaudited clients (#3 #6). The findings are: Observation on 6/4/21 at 12:30 pm of Client #1's room revealed the following: -- An unopened box with a tube of Preparation H in a basket on a dresser. -- A 1/2 empty tube of Clotrimazole Cream on the top of a tall dresser. Interview on 6/4/21 with Staff #1 revealed the following information: -- She understood that all medications need to be locked up. -- Client #1 should not have had those medications in her room. -- She was not aware that these medications were in the client's room. Observation on 6/15/21 at 2:15 pm revealed the following medications on the shelves of the computer desk: -- A bottle 3/4 full of Calamine Lotion. -- 2 bottles of Rolaids. -- 2 bottles of Flonase dispensed from the pharmacy on 10/28/20 and 3/9/21 belonging to Client #1.	V 120		

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V 120	Continued From page 20 -- An inhaler of Albuterol belonging to Client #1. -- An inhaler of Flovent belonging to Client #1. -- A Proair inhaler. -- A tube of Clotrimazole Cream 1% belonging to Client #2. -- On the top shelf of this desk shelf were the staff keys, including the key to the medication closet. Observation on 6/3/21, 6/4/21, 6/7/21 and 6/11/21 revealed the bottle of Calamine lotion and the 2 bottles of Rolaids were on the computer desk shelves. Observation throughout the survey (6/3/21, 6/4/21, 6/7/21, 6/11/21 and 6/15/21) at random times revealed the clients entered the office area when staff was in the office. Interview on 6/15/21 with the Licensee/Facility Director revealed the following information: -- The inhalers were in the office "because [Client #1] uses them so much." -- She understood that all medications need to be locked up. This deficiency is cross referenced into 10A NCAC 27G .1701 SCOPE (V-293) for a Type A1 rule violation and must be corrected within 23 days.	V 120		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to	V 132		

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V 132	Continued From page 21 any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.	V 132		

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V 132	Continued From page 22 This Rule is not met as evidenced by: Based on interview and record review the facility failed to report an allegation of abuse to the North Carolina Health Care Personnel Registry (HCPR) and failed to protect clients during the investigation process affecting 1 of 1 Former Staff (FS #10). The findings are: Review on 6/4/21 of Ct #1's record revealed the following information: -- A 16-year-old female. -- Date of admission to the facility: 8/28/20. -- Diagnoses include Major Depressive Disorder-Unspecified, Unspecified Disruptive Impulse Control and Conduct Disorder, ODD (Oppositional Defiant Disorder)-Moderate, ADHD (Attention Deficit Hyperactivity Disorder) -Predominantly Hyperactive Impulsive Presentation, Generalized Anxiety Disorder, Panic Attacks, Psychosis - NOS (not otherwise specified), History of self-harm, Parent - child relational problems and Asthma. -- Psychological testing dated 12/17/20: "FSIQ (Full Scale Intelligence Quotient) = 80 - low average." -- "Does the member (Ct. #1) have a history of being neglected, or physically, emotionally or sexually abused? Yes." Review on 6/7/21 of a document provided by the Licensee/Facility Director (L/FD) revealed the following information regarding an internal investigation: "Savin Grace Investigation report and findings: Completed by [L/FD] Date completed: April 23, 2021 On April 12th 2021, I [L/FD] received a call from [Staff #1], [Staff #1] was informed by staff [the Qualified Professional] that client [Ct. #1] stated	V 132		

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that a staff [FS #10] showed her, buttocks. I proceeded to ask staff all the details in order to begin my investigation. I immediately telephoned [FS #10] and questioned her on the allegation made against her, [FS #10] denied that anything of this happened. I was informed that the incident allegedly happened on April 11, 2021 on the evening shift. I telephoned [Staff #5] and ask that he review the cameras and report his findings. [Staff #5] informed me the following day that he reviewed the cameras and he did not see anything remotely close to staff [FS #10] exposing herself to client [Ct. #1]. After reviewing the camera, myself, I did not see any such actions or any inappropriate behavior by [FS #10]. Which concluded my investigation.

On April 19, 2021, I received a telephone call from [Staff #1] informing me the client [Ct.#1] stated that she informed her therapist that staff [FS #10], showed her buttocks and that the therapist stated that she would have to report it. From my previous experience with complaints and or allegations I expect the state to come out a complete an investigation in the matter.

On April 21, 2021 Savin Grace received a visits from a CPS (Child Protective Services) worker that was at Savin Grace to complete an investigation regarding the allege behaviors of staff [FS #10]. The CPS interviewed each client (all 4 clients) that was in the facility. [Name of CPS worker] spoke with myself and [Staff #5] regarding the allegations. I informed [CPS worker], I had not written up my report but in fact did investigate the allegations immediately once I was made aware of them.

As this is and ongoing investigation my final report will be made after the CPS investigation has been fully completed.

[FS #10] has not been on schedule since April 18th 2021 and have been suspended from

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working with any Savin Grace clients pending the investigation outcomes.
This concludes my investigative report, a follow up will be written as CPS conclude."

Review on 6/4/21 of the "Staff Communication Log" revealed that FS #10 worked in the facility following the date of the allegation (4/11/21) on the following occasions: 4/14/21 (8 am to 8pm) and 4/27/21 (8 am to 8 pm).

Review on 6/11/21 of FC #4's April 2021 Medication Administration Record revealed FS #10's initials (documenting that she administered medications) on 4/13/21 and 4/14/21.

Interview on 6/7/21 with the CPS worker investigating the above allegation revealed the following information:
-- She has not completed this investigation yet.
-- The recorded film she, the L/FD and Staff #5 watched was recorded on the date of the allegation, however the only thing viewed by them was video of the kitchen area.
-- Client #1 alleged the incident occurred in the living room area.
-- She asked the L/FD to get back with her when she would be able to view the living room video.
-- The L/FD agreed to do that.
-- The L/FD has not contacted her yet.

Review on 6/11/21 of the North Carolina Incident Reporting Response System (IRIS) revealed that no incident report had been completed for the above allegation (reporting thru IRIS triggers a notification to the HCPR for investigation).

Interview on 6/15/21 with the L/FD revealed the following information:
-- She viewed the video recording with the CPS

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V 132	Continued From page 25 worker. -- She doesn't think that the camera in the living room works. -- She could check with Staff #5 to see if there was a recording. Review on 6/11/21 of Client #1's record revealed documentation from her Therapist as follows: -- 4/22/2021 - "Intervention: ...Therapist processed with client an incident with group home staff and praised client for sitting in her "truths.'" Effectiveness: ...She was able to discuss an incident with group home staff, but states that everyone is stating that she is lying." -- 5/6/2021 - "Intervention: ...Therapist assessed client's week since previous session. Therapist processed with client an incident that occurred with client and group home staff that resulted in client cutting ... Effectiveness: ...She became tearful when discussing her uncontrollable emotions associated with the incident and being called a liar. The client disclosed that this was her first time cutting and had marks on her arm around the wrist area ..." Interview on 6/4/21 with Client #1 revealed the following information: -- "She (the former staff) pulled her pants down." -- " I don't want to talk about it any more, no one believes me, my Mom my social worker or the staff." This deficiency is cross referenced into 10A NCAC 27G .1701 SCOPE (V-293) for a Type A1 rule violation and must be corrected within 23 days.	V 132		

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V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE (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	V 293		

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V 293	Continued From page 27 gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility 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 observation, interview and record review the facility staff failed to provide intensive, active therapeutic treatment and interventions to ensure safety and to minimize the occurrence of behaviors, failed to assure staff were providing continuous supervision during sleep hours and failed to operate within the scope it was licensed for by admitting a 5th client while it was operating at its licensed capacity of 4 clients affecting 2 of 2 current audited clients (#1 #2), 2 of 2 current unaudited clients (#3 #6) and 2 of 2 former clients (FC #4 FC #5). The findings are: Cross Reference: 10A NCAC 27G .0205, ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN, Tag V-111. Based on interview and record review, the facility failed to assure an assessment was completed for each client prior to the delivery of services affecting 2 of 2 audited current clients (#1 #2) and 2 of 2 former clients (FC #4 FC #5).	V 293		

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V 293	Continued From page 28 Cross Reference: 10A NCAC 27G .0205, ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN, Tag V-112. Based on interview and record review, the facility failed to develop and implement strategies and interventions within a treatment plan to address behaviors of elopement, sexualized behaviors and self injury affecting 1 of 2 former clients (FC #4). The findings are: Cross Reference: 10A NCAC 27G .0209 MEDICATION REQUIREMENTS, Tag V-118. Based on interview and record review, the facility failed to assure a) medications were administered on the written order of a Physician, b) all MARs were kept current and c) staff demonstrated competence in medication documentation and administration affecting 1 of 2 current audited clients (#2) and 2 of 2 former clients (FC #4 FC #5). Cross Reference: 10A NCAC 27G .0209 MEDICATION REQUIREMENTS, Tag V-120. Based on observation and interview, the facility failed to assure that all medications were stored in a securely locked space affecting 2 of 2 current audited clients (#1 #2) and 2 of 2 current unaudited clients (#3 #6). Cross Reference: G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY, Tag V-132. Based on interview and record review the facility failed to report an allegation of abuse to the North Carolina Health Care Personnel Registry (HCPR) and failed to protect clients during the investigation process affecting 1 of 1 Former Staff (FS #10). Cross Reference: 10A NCAC 27G .1704,	V 293		

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V 293	Continued From page 29 MINIMUM STAFFING REQUIREMENTS, Tag V-296. Based on observation, interview and record review, the facility failed to assure the minimum number of direct care staff were on duty and awake affecting 2 of 2 current audited clients (#1 #2), 2 of 2 current unaudited clients (#3 #6) and 1 of 2 former clients (FC #4). Cross Reference: 10A NCAC 27E .0107, TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS, Tag V-536. Based on interview and record review, the facility failed to assure all staff prior to delivering services to clients receive training in the use of Alternatives to Restrictive Interventions for 9 of 9 current staff (#1 - #8 and the Qualified Professional). Cross Reference: 10A NCAC 27E .0108, TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT, Tag V-537. Based on interview and record review, the facility failed to assure all staff had current training in Seclusion, Physical Restraints and Isolation Time-Out for 9 of 9 current staff (#1 - #8 and the Qualified Professional). Review on 6/3/21 and 6/4/21 of FC #4's record revealed the following information: -- A 16-year-old female. -- Date of admission to the facility: 11/5/20. -- Date of discharge: unknown (no Discharge Summary completed). -- Transported to the hospital by staff on 5/28/21 for a psychiatric evaluation. -- She was AWOL (away with out leave) from the facility from 5/1/21 and returned to the facility on 5/11/21.	V 293		

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-- Diagnoses include Major Depressive Disorder, Disruptive Mood Dysregulation Disorder, PTSD (Post Traumatic Stress Disorder), ADHD (Attention Deficit Hyperactivity Disorder) and ODD (Oppositional Defiant Disorder).

Review on 6/11/21 of FC #5's record revealed the following information:
-- A 17 year old female.
-- Was admitted to the facility on 5/5/21, and discharged on 5/11/21 (total of 7 days).
-- Diagnoses include Bipolar Disorder, ADHD, ODD and Borderline Personality Disorder.

Review on 6/11/21 of the "Staff Communication Log" revealed the following information:
-- 5/11/21: FC # 4 returned to the facility from an elopement occurring 5/5/21 through 5/11/21.
-- Documentation by staff on this log indicates "5 clients in facility."

Review on 6/11/21 of FC #5's May 2021 MAR revealed she was administered medication on 5/11/21.

Review on 6/3/21 of the facilities' 2021 license revealed that it is licensed for occupancy of 4 clients.

Interview on 6/15/21 with the Licensee/Facility Director (L/FD) revealed the following information;
-- FC #5 was admitted on an "emergency basis" and was only in the facility for a week.
-- She acknowledged that FC #5 was admitted to the facility as a fifth client while FC #4 was AWOL.
-- She offered no other explanation of admitting a new client while the facility was at maximum occupancy despite 1 client being gone from the facility.

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V 293	Continued From page 31 Review on 6/15/21 of a Plan of Protection dated 6/15/21 written by the L/FD revealed the following information; "Savin Grace will thoroughly evaluate our current intake process and be more diligent when screening potential residents to ensure that our facility can meet their level of care. Savin Grace will implement refresher training for all current staff and implement on-going training to ensure that all staff have the necessary tools to perform their responsibilities. Savin Grace will ensure that all locks to include window alarms are operable and is functioning properly. Savin Grace will ensure that all medications are stored in a lock box in a locked closet. All cleaning supplies will be stored in a lock cabinet. Savin Grace CEO (the L/FD) revised its intake/screening form to be used for every referral to our services, to ensure that Savin Grace have the capabilities to service the resident and or make the appropriate recommendations. Savin Grace have began the hiring process and have four new staff that will be trained and begin working to ensure that we maintain the proper staff to client ratios. Training have been set and should be completed by Sunday June 30th to include behavior management, medication, CPR/FA (Cardio Pulmonary Resuscitation/First Aid) and Savin Grace agency required training. Training will be maintained in employee file. All door locks will be checked and replace as needed to include window locks and bathroom doors." This facility serves up to 4 adolescent girls with diagnoses such as: Major Depressive Disorder, Impulse Control Disorder, Conduct Disorder, Oppositional Defiant Disorder, Attention Deficit	V 293		

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Hyperactivity Disorder, Generalized Anxiety Disorder, Panic Attacks, Disruptive Mood Dysregulation Disorder, Post Traumatic Stress Disorder, Bipolar Disorder and Borderline Personality Disorder.
These clients require 24 hour supervision due to documented history of exhibiting unsafe behaviors such as running and self harm. The facility was frequently understaffed (based on interview and record review), leaving only 1 staff available to supervise and provide services to 4 clients at a time. FC #4 had a previous history of elopement and displayed this behavior 5 times while residing at the facility resulting in being gone from the facility without supervision for a total of 35 days. She would remain gone for between 2 days and 20 days. The facility failed to develop and implement strategies to address FC #4's running away behaviors. While unsupervised in the community, this client engaged in promiscuous behavior exposing herself to sexually transmitted diseases. Following this behavior, she required several courses of antibiotic therapy. There were delays in the initiation of each of these antibiotics (from 4 to 11 days), delaying the lessening of the symptoms associated with these infections. No additional interventions or extra staff were put in place to assure the safety of this client.
Client #1 informed multiple staff that a staff person exposed herself to them. While the L/FD initiated an internal investigation, this staff remained working in the facility during this investigation and nothing was put into place to ensure the safety of Client #1 or any of the other clients present in the facility. The L/FD failed to report this allegation to the HCPR. The L/FD relied on the investigation done by Child Protective Services to complete her investigation.
Medications, both prescription and

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V 293	Continued From page 33 nonprescription were given without a Physician's order, Clients were delayed in receiving antibiotics to treat symptoms of infections, and medications were observed throughout the facility in unlocked areas accessible to the clients. The facility was responsible for medical neglect (delay of Antibiotic administration) and not obtaining timely follow-up medical treatment for clients. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 293		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff	V 296		

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V 296	Continued From page 34 during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure the minimum number of direct care staff were on duty and awake affecting 2 of 2 current audited clients (#1 #2), 2 of 2 current unaudited clients (#3 #6) and 1 of 2 former clients (FC #4). The findings are: Review on 6/4/21 of Client #1's record revealed the following information:	V 296		

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V 296	Continued From page 35 -- A 16-year-old female. -- Date of admission to the facility: 8/28/20. -- Diagnoses include Major Depressive Disorder-Unspecified, Unspecified Disruptive Impulse Control and Conduct Disorder, ODD (Oppositional Defiant Disorder)-Moderate, ADHD (Attention Deficit Hyperactivity Disorder)-Predominantly Hyperactive Impulsive Presentation, Generalized Anxiety Disorder, Panic Attacks, Psychosis - NOS (not otherwise specified), History of self-harm, Parent - child relational problems and Asthma. -- Psychological testing dated 12/17/20: "FSIQ (Full Scale Intelligence Quotient) = 80 - low average." -- "Does the member (Ct. #1) have a history of being neglected, or physically, emotionally or sexually abused? Yes." Review on 6/7/21 of Client #2's record revealed the following information: -- A 15 year old female. -- Admitted to the facility on 12/5/20. -- Diagnoses include Major Depressive Disorder, Anxiety and ODD. Review on 6/3/21 and 6/4/21 of FC #4's record revealed the following information: -- A 16-year-old female. -- Date of admission to the facility: 11/5/20. -- Date of discharge: unknown (no Discharge Summary completed). -- Transported to the hospital by staff on 5/28/21 for a psychiatric evaluation. -- Diagnoses include Major Depressive Disorder, Disruptive Mood Dysregulation Disorder, PTSD (Post Traumatic Stress Disorder), ADHD and Oppositional Defiant Disorder. A. Observation on 6/3/21 at 9:30 am revealed	V 296		

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V 296	Continued From page 36 only 1 staff in the facility (the Qualified Professional (QP)) with 4 clients. During interview on 6/3/21 at 9:40 am the QP stated the following: -- "The nine o'clock person (staff) just left." -- "Another staff is on her way in." -- "There are 2 staff (on duty) at all times." -- "I was here before (worked at the facility), I came back last year." -- She works Monday through Friday on the day shift. -- Shifts are 12 hours (8 am until 8 pm and 8 pm until 8 am). Observation on 6/3/21 at 10:45 am revealed the following: -- The Licensee/Facility Director (L/FD) came into the facility. -- The L/FD stayed at the facility approximately 20 minutes (until about 11:05 am). During interview on 6/3/21 at 10:50 am the L/FD stated that she was feeling very sick and she was going to see a Doctor. Observation on 6/3/21 at 11:30 am revealed Staff #1 arrived at the facility. Observation on 6/4/21 at 9:00 am revealed Staff #1 was working at the facility. During interview on 6/4/21 at 9:15 am, Staff #1 confirmed that she had been at the facility since the previous day and worked the night shift on 6/3/21 (this represents an almost 24-hour period). Interview on 6/4/21 with Client #2 revealed the following information: -- Staff #1 worked the previous night shift alone.	V 296		

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V 296	Continued From page 37 -- "Staff sleep on the couch or the chair in the office." -- On the day shift "2 staff work 2 or 3 days a week, otherwise it's 1 staff (on duty each shift)." Interview on 6/4/21 with Client #3 revealed the following information: -- Staff #1 worked the previous night shift alone. -- She confirmed that staff sleep at night. Interview on 6/4/21 with Client #4 revealed the following information: -- Staff #1 worked the previous night shift. -- She doesn't know if staff sleep on the night shift as she was just admitted to the facility 2 days prior. B. Review on 6/15/21 of the "Staff Communication Log" revealed the following instances of only 1 staff working; -- 6/1/21 - 8 am to 8 pm (Staff #7). No documentation on this log for 8 pm to 8 am. -- 6/2/21 - No documentation of anything on this log (8 am to 8 pm or 8 pm to 8 am). -- 6/3/21 - 8 pm to 8 am (Staff #1). -- 6/4/21 - No documentation on this log for 8 pm to 8 am. -- 6/5/21 - No documentation of anything on this log (8 am to 8 pm or 8 pm to 8 am). -- 6/6/21 - No documentation on this log for 8 am to 8 pm. -- 6/6/21 - 8 pm to 8 am (Staff #3). -- 6/7/21 - 8 am to 8 pm (Staff #1). No documentation on this log for 8 pm to 8 am. -- 6/8/21 - 8 am to 8 pm Staff #1 and Staff #8 (Staff #8 - came to the facility at approximately 12:00 pm). (** See below for information regarding Staff #8) -- 6/8/21 - No documentation on this log for 8 pm to 8 am.	V 296		

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V 296	Continued From page 38 -- 6/9/21 - 8 am to 8 pm (Staff #1 and Staff #8) -- 6/9/21 - 8 pm to 8 am (Staff #3). -- 6/10/21 - 8 am to 8 pm (Staff #5 and Staff #8) -- 6/10/21 - 8 pm to 8 am (Staff #5 - this represents a 24 hour period of work Staff #5). -- 6/11/21 - 8 am to 8 pm (Staff #1 and Staff #8). -- 6/11/21 - 8 pm to 8 am (Staff #7). -- 6/12/21 - 8 am to 8 pm (Staff #7 - this represents a 24 hour period of work Staff #7). -- 6/12/21 - 8 pm to 8 am (Staff #3). -- 6/13/21 - 8am to 8 pm (Staff #1). -- 6/13/21 - 8 pm to 8 am (Staff #3). -- 6/14/21 - 8 am to 8 pm (Staff #1 and Staff #8). Review on 6/15/21 of Staff #8's personnel file revealed the following information; -- No date of hire. -- A Job Description for Paraprofessional signed on 6/8/21. Interview on 6/15/21 with the L/FD revealed the following information; -- Staff #8 is not hired yet, she is "just shadowing" other staff to assess if she will be hired as an employee. -- She was unaware that Staff #8 could not provide any services, including supervision of clients and could not be counted as a "working" staff member until her training was completed. C. Review on 6/7/21 of Client #3's progress notes revealed that Staff #1 worked on 5/24/21 and signed this note for the 8:00 am to 8:00 pm shift. Staff #1 also worked on 5/24/21 and signed the note for the 8:00 pm to 8:00 am shift (this represents working continuously for a 24-hour period). D. Interview on 6/4/21 with Client #1 revealed the following information;	V 296		

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V 296	Continued From page 39 -- "[Ct. #3] threw Clorox in my face and bleached my clothes the Friday before Easter (4/2/21)." -- "I beat her up." -- Staff did not take her to the Emergency Room (ER) for treatment. -- She wanted to go to the ER, "my eyes were burning." Review on 6/4/21 of the "Staff Communication Log" revealed that there was only 1 staff on duty when the above incident occurred. Interview with the L/FD on 6/11/21 revealed the following information; -- She has been having a difficult time since the COVID-19 pandemic hiring new staff and retaining old staff. -- She does not have enough current staff to cover all of the shifts needing covered. -- She is in the process of interviewing and hiring new staff. This deficiency has been cited previously two times since the original citation on 3/6/2020 (9/2/20 and 3/6/20). This deficiency is cross referenced into 10A NCAC 27G .1701 SCOPE (V-293) for a Type A1 rule violation and must be corrected within 23 days.	V 296		
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	V 536		

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V 536	Continued From page 40 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 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	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 536	Continued From page 41 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 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.	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 536	Continued From page 42 (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. (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	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 536	Continued From page 43 competence by completion of coaching or train-the-trainer instruction. (I) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure all staff prior to delivering services to clients receive training in the use of Alternatives to Restrictive Interventions for 9 of 9 current staff (#1 - #8 and the Qualified Professional). The findings are: 1. Review on 6/11/21 of the Qualified Professional's (QP's) personnel file revealed the following information: -- No documentation of a date of hire. -- A job description for QP signed and dated 2/9/21. -- An NCI (North Carolina Interventions) certificate dated 10/19/20, instructed by and signed by the Licensee/Facility Director (L/FD). 2. Review on 6/11/21 of Staff #1's personnel file revealed the following information: -- Date of hire 2/18/16. -- Paraprofessional. -- No documentation of any training on Alternatives to Restrictive Interventions. 3. Review on 6/11/21 of Staff #2's personnel file revealed the following information: -- Date of hire 1/12/14.	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 536	Continued From page 44 -- Paraprofessional. -- No documentation of any training on Alternatives to Restrictive Interventions. 4. Review on 6/11/21 of Staff #3's personnel file revealed the following information: -- No documentation of a date of hire. -- Paraprofessional. -- An NCI certificate dated 7/9/20, instructed by and signed by the L/FD. 5. Review on 6/11/21 of Staff #4's personnel file revealed the following information: -- Date of hire 5/3/14. -- Former QP, now working as direct care staff. -- No documentation of any training on Alternatives to Restrictive Interventions. 6. Review on 6/11/21 of Staff #5's personnel file revealed the following information: -- Date of hire 1/16/12. -- Paraprofessional. -- A "Savin Grace Behavioral Interventions" certificate dated 12/29/18. This training was instructed by the L/FD. 7. Review on 6/11/21 of Staff #6's personnel file revealed the following information: -- No documentation of a date of hire. -- A Health Care Personnel Registry check and criminal background check dated 2/19/21. -- Paraprofessional. -- An NCI certificate dated 2/27/21, instructed by and signed by the L/FD. 8. Review on 6/11/21 of Staff #7's personnel file revealed the following information: -- Date of hire 3/21/21 -- Paraprofessional. -- An NCI certificate dated 3/29/21, instructed by	V 536		

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V 536	Continued From page 45 and signed by the L/FD. 9. Review on 6/15/21 of Staff #8's personnel file revealed the following information: -- No date of hire -- A Job Description for Paraprofessional signed on 6/8/21. -- No documentation of any training in the Use of Seclusion, Physical Restraints and Isolation Time-Out. Interview on 6/15/21 with the L/FD revealed the following information; -- Staff #8 is not hired yet, she is "just shadowing" other staff to assess if she will be hired as an employee. -- She used to be a certified NCI instructor. -- She was aware that as of January 1, 2018 NCI training would no longer be recognized as an approved training curriculum by DHHS (Department of Health and Human Services). -- She thought she could still instruct her staff on the NCI methods and techniques. -- She used the old NCI template to create staff certificates for personnel files. -- She renamed the NCI curriculum "Savin Grace Behavioral Interventions." This deficiency is cross referenced into 10A NCAC 27G .1701 SCOPE (V-293) for a Type A1 rule violation and must be corrected within 23 days.	V 536		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT	V 537		

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V 537	Continued From page 46 (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. (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	V 537		

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V 537	Continued From page 47 (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. (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	V 537		

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V 537	Continued From page 48 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. (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.	V 537		

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V 537	Continued From page 49 (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 interview and record review, the facility failed to assure all staff had current training in Seclusion, Physical Restraints and Isolation Time-Out for 9 of 9 current staff (#1 - #8 and the Qualified Professional). The findings are: 1. Review on 6/11/21 of the Qualified Professional's (QP's) personnel file revealed the following information: -- No documentation of a date of hire. -- A job description for QP signed and dated 2/9/21. -- An NCI (North Carolina Interventions - part B) certificate dated 10/19/20, instructed by and signed by the Licensee/Facility Director (L/FD). 2. Review on 6/11/21 of Staff #1's personnel file	V 537		

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V 537	Continued From page 50	V 537		

revealed the following information:
-- Date of hire 2/18/16.
-- Paraprofessional.
-- No documentation of any training in the Use of Seclusion, Physical Restraints and Isolation Time-Out.

3. Review on 6/11/21 of Staff #2's personnel file revealed the following information:
-- Date of hire 1/12/14.
-- Paraprofessional.
-- No documentation of any training in the Use of Seclusion, Physical Restraints and Isolation Time-Out.

4. Review on 6/11/21 of Staff #3's personnel file revealed the following information:
-- No documentation of a date of hire.
-- Paraprofessional.
-- An NCI (part B) certificate dated 7/9/20, instructed by and signed by the L/FD.

5. Review on 6/11/21 of Staff #4's personnel file revealed the following information:
-- Date of hire 5/3/14.
-- Former QP, now working as direct care staff.
-- No documentation of any training in the Use of Seclusion, Physical Restraints and Isolation Time-Out.

6. Review on 6/11/21 of Staff #5's personnel file revealed the following information:
-- Date of hire 1/16/12.
-- Paraprofessional.
-- A "Savin Grace Behavioral Interventions (part B)" certificate dated 12/29/18. This training was instructed by the L/FD.

7. Review on 6/11/21 of Staff #6's personnel file revealed the following information:

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V 537	Continued From page 51 -- No documentation of a date of hire. -- A Health Care Personnel Registry check and criminal background check dated 2/19/21. -- Paraprofessional. -- An NCI (part B) certificate dated 2/27/21, instructed by and signed by the L/FD. 8. Review on 6/11/21 of Staff #7's personnel file revealed the following information: -- Date of hire 3/21/21 -- Paraprofessional. -- An NCI certificate (part B) dated 3/29/21, instructed by and signed by the L/FD. 9. Review on 6/15/21 of Staff #8's personnel file revealed the following information: -- No date of hire -- A Job Description for Paraprofessional signed on 6/8/21. -- No documentation of any training in the Use of Seclusion, Physical Restraints and Isolation Time-Out. Interview on 6/15/21 with the L/FD revealed the following information: -- Staff #8 is not hired yet, she is "just shadowing" other staff to assess if she will be hired as an employee. -- She used to be a certified NCI instructor. -- She was aware that as of January 1, 2018 NCI training would no longer be recognized as an approved training curriculum by DHHS (Department of Health and Human Services). -- She thought she could still instruct her staff on the NCI methods and techniques. -- She used the old NCI template to create staff certificates for personnel files. -- She renamed the NCI curriculum "Savin Grace Behavioral Interventions."	V 537		

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V 537	Continued From page 52 This deficiency is cross referenced into 10A NCAC 27G .1701 SCOPE (V-293) for a Type A1 rule violation and must be corrected within 23 days.	V 537		