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V 000	INITIAL COMMENTS An annual and complaint survey was completed on July 2, 2021. The complaint was substantiated (#NC00176033). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G.1700 Residential Treatment Staff Secure for Children or Adolescents.	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures	V 110		

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for the initiation of the individualized supervision plan upon hiring each paraprofessional.

This Rule is not met as evidenced by:
Based on record reviews and interviews, 2 of 3 staff (Cottage Supervisor and Residential Director) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are:

Refer to Tag V112 for additional information.

Review on 6/15/21 of the Residential Director's employee file revealed:
-hire date 1/30/17.
-promoted to current position on 10/20/20.
-11/20/19 - TCI (Therapeutic Crisis Intervention) Trainer Associate - expires 11/20/21.

Review on 6/16/21 of Client #1's record revealed:
-admitted 12/23/20.
-17 years old - identified as a transgendered male.
-diagnoses of Post-Traumatic Stress Disorder, Major Depressive Disorder with psychotic features, Generalized Anxiety Disorder with Obsessive-Compulsive features, Gender Dysphoria, Specific Learning Disorder and Attention-Deficit Hyperactivity Disorder.
-5/11/21 - most recent Comprehensive Clinical Assessment update - "...since admission to Reuter he has demonstrated the following behavior: daily self-harm that includes cutting herself with paper or using her finger nail, she

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has also carved the name of her abuser into her stomach with her finger nail, head banging, leaving the cottage to walk around campus without permission and reports suicidal ideation with a plan but with no means to complete. Property destruction including breaking windows and has engaged in violence towards staff which included biting, licking, hitting and kicking, requires 1-1 support to regulate."

Review on 6/16/21 of Client #1's Crisis Prevention and Intervention Plan initially dated 12/9/20 and last revised on 6/11/21 revealed:
-"What are some events or situations that have caused me trouble in the past?...I get triggered when people touch me."
-4/6/21 - Triggers: "...[Client #1] has reported that the gym and weight barn are triggers..."

-"What are the early warning signs that I am not doing well?... (Prevention and Early Intervention Strategies) I run to my room and isolate myself. I shut the door. I stop talking."
-3/1/21 - Strategies: "Presenting a firm schedule with alternatives if [he] doesn't like an activity. Appealing to [his] interests..."
-4/6/21 - Strategies: "Making a plan, providing distractions..."

Review on 6/21/21 of Residential Multidisciplinary Team Meetings for Client #1 from March 2021 through May 2021 revealed:
-meetings on 3/30/21, 4/20/21 and 5/18/21.
-strategies to prevent future incidents/outbursts: structured activities that allowed client to have staff's attention - he preferred 1-1 staff.

Review on 6/15/21, 6/16/21, 6/17/21, 6/22/21, 6/23/21, and 6/24/21 of facility Incident Reports (IR), facility Level III Restrictive Intervention

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Incident Reports (RI) and the North Carolina Incident Response Improvement System (IRIS) for Client #1 from March 2021 to June 2021 revealed:

-3/27/21 1:02 p.m. IRIS -RI Client head banged against a concrete wall and would not allow staff to use headboard. Staff utilized a seated restraint for approximately 13 minutes. The summary of incident described a situation where the client did not want to watch the movie being played (Hunger Games) as it was too violent.
Student re-engagement: The client was brought back to join the rest of the movie block.
Ways to manage the identified trigger: "Proactive alternate activity during non-preferred blocks."

-4/6/21 8:42 p.m. IRIS -RI Client attempted to open his room window. Staff closed the window and blocked him from it. Client ran toward the door and staff tried to block him from leaving. Client began to push and kick staff. Staff initiated a "yoke" (the initiation of a RI). Staff attempted to initiate a second RI but the client's legs were locked. Staff released the "yoke" and tried to block him from getting out the side door. Client was able to run outside again.
Environmental effects: it was less structured due to it being "choice time."

-5/8/21 1:00 p.m. IR- Self injurious. During self-support activity, staff blocked client's room as he attempted to go to his room after stating he wanted to hurt himself. Two staff entered his room as he went inside. Staff provided proximity as client began to hit his head. Staff called for additional staff as client began to hit his head with increasing intensity and frequency. Staff blocked the windows as client attempted to open them and jump out of them.

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To prevent: discuss with clinician how to best support client in setting appropriate boundaries with staff and advocating to check-in with them.

-5/8/21 8:10 p.m. - IRIS - RI. Client was in the gym and upset about mom and non-preferred staff. He began to lightly head bang. He transitioned back to the cottage and began head banging in room. Client went outside and engaged in verbal threats towards staff. His behavior escalated and he started kicking glass by the front door and it shattered. Client returned to his room and began head banging. Incident ended in a restrictive intervention.

-5/9/21 12:02 p.m. IR- Self injurious. Client was in the gym and claimed he was lightly tapping his head. He was transitioned to his room. Client head banged and attempted to exit through his window. Staff provided proximity and closed the window. Staff utilized the "breaking up fight technique" in order to prevent client from going towards the staff at the side door. Staff utilized the technique again as he tried to push past staff in the hallway going towards the common area. Staff continued to utilize the protective stance and proximity as client continued trying to exit the cottage. Staff entered client's room as he entered and tried to leave through the window. Staff utilized the protective stance to prevent him from doing so. Staff continued to utilize protective stance as client continued going from window to window and trying to go out the door. Staff utilized proximity as client continued to head bang and run around his room in order to do so as staff was preventing him. Staff set the expectation for client to make a plan in order for him to leave his room. To prevent: staff need to create plan before client calls mom; increased checks during other's crisis; continue to foster independent living skills.

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V 110	Continued From page 5 -5/23/21 4:30 p.m. IR- Self-injurious. Client was in gym and had light head banging for approximately 3 minutes. He was transitioned to his room and head banged. Client transitioned to the support room during dinner. Staff entered support room and used headboard when staff heard light head banging. Staff continued to use headboards until client said he was done because "...this isn't working," Staff set expectation that client would have to make a plan before leaving the support room. To prevent: during unstructured blocks, staff can manage by proactive check-ins to make a plan and proximity to ensure follow through. -5/29/21 4:25 p.m. IR- Self injurious. Safety check of client in his room. Client was lightly tapping his head on brick wall. Staff used a pillow between his head and a wall. Client had a phone call with his mother and was yelling at his mother. Staff followed client onto porch and client returned to common area. Staff gave client scissors to cut off end of an anklet he was wearing. When given a direct statement to return scissors, client responded aggressively that he wasn't giving scissors back. Staff provided grounding technique of holding the client's hands which continued until client handed over the scissors. Client went outside and staff used proximity to prevent client from kicking windows. Staff informed client a restrictive intervention would be initiated if he didn't stop hitting windows. Client walked around the back of the cottage and lightly tapped his knuckles on a brick wall. Staff placed a headboard between client's fist and wall. Staff encouraged client to hit headboard instead of wall and provided positive encouragement for hitting headboard with "cool karate kick." Client showed safety, returned to cottage and then room.	V 110		

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Trigger: client started day in "unusually bad mood", client expressed bad phone call with mom as trigger.
To prevent: staff will be very mindful of this behavior possibly occurring when client has phone calls with mom.

-6/2/21 5:35 p.m. - IR - Client in gym - Client was picking at wound on his foot and punching a wall. In the cottage, client was "weaponing forks," grabbed pen and ran outside.
To prevent: staff proactively monitoring for potential triggers from peers, keeping kitchen managed, removing the audience.

-6/5/21 12:45 p.m. IRIS -RI - Client was in the gym, isolated himself, and said he was head banging. In the cottage, he head banged on the wall and the floor. This resulted in a restrictive intervention.
To prevent: continue proactive support and options for client. Brainstorm ideas with clinician on how to encourage client to seek positive attention from staff.

Review on 6/29/21 of the Reuter Cottage Schedule Template for 2021 provided by the Residential Director revealed:
-unstructured time of self-reflection/self-support/choice time scheduled 4 times a day during weekdays and 5 times a day on weekends.
-movie time was scheduled 2 times a day on weekends.
-the gym was scheduled for weekends.
-there was no alternative plan/schedule for Client #1.

Interview on 6/11/21 with Staff #1 revealed:
-she was the Lead Residential Counselor and

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typically worked the second shift.
-she learned of clients' needs, triggers and behaviors as "...kids will tell you..."
-there was a staff meeting each week and any updates for a client were emailed.
-Client #1 was attention seeking, he head bangs, but unlike other clients' who are self-injurious, he was not harming himself, it was more attention seeking.
-"...try to be pro-active, keep him engaged, distractions...very kiddish kind of engagement...behavior not predictable..."
-when he was head banging it was more like "notice me."
-they first gave him prompts and try to redirect him. If he keeps going they would use a headboard to block his head from hitting the concrete wall.

Interviews on 6/11/21 and 6/23/21 with Staff #2 revealed:
-she learned about new clients when they arrived.
-there were meetings every Wednesday. They met as a cottage and the supervisor would inform them of new clients, and the counselor would notify them of specific client strategies.
-this usually happened within a couple days of admission.
-the client will also complete paper work regarding what makes them angry, triggers, what helps them, and their interest.
-Client #1: "...at beginning he was doing really good. I don't' know what happened. He might be scared of going home, having behavior as avoidance...to avoid going home. When he talks of going home, he gets anxious and see increasing in behaviors. ..."
-she attempted to use verbal re-direction to distract him from self-harm with drawing or painting on his arm.

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Interview on 6/24/21 with Staff #3 revealed:
-she learned about clients' triggers, strategies, what works, what doesn't work via a support plan completed by intake staff.
-it was better to hear from the client what worked and what didn't work; as they got to know the client they could update the support plan.
-when Client #1 was self-harming "heavily," scratching at arms, or legs she would try to distract him verbally or take his hands and gently redirect him.
-physical touch was the most effective. Like just putting her hand on the arm of the client.

Interview on 6/24/21 with the Cottage Supervisor revealed:
-she worked on the floor with the clients. Every Tuesday she had the client's come to the office to check-in, see what they need from the store and she would pick it up for them.
-the staff came together at the end of their shift to debrief, discuss what happened on their particular shift and if there were any incidents.
-staff rely on intake information to know what triggers a client and what their strategies were.
-there was a white board in the office that had the client's initials, age, triggers, and what they liked; they would also talk to the clients and find out.
-there was also an internal document sent out 3 times a day via email detailing how each client did on each shift.
-when asked about training for the Psychiatric Residential Treatment Facility (PRTF) staff coming to the level III cottage - "theoretically it's in a pre-service."
- if the staff do not know what interventions may or may not be used she will sit down with that staff and use the minutes from their team meetings to teach them about clients' and

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possible interventions to be used.
-a strategy recently used on Client #1 that worked, was to take off marker tops, and changed the caps as a distraction.
-the Cottage Supervisor's meet every Tuesday and discuss other strategies and share announcements with staff.

Interviews on 6/16/21, 6/17/21 and 6/24/21 with the Residential Director revealed:
-his role was to oversee the staff and supervisors of all residential programs.
-he was also one of the TCI trainers.
-the staff were aware of client's issues, triggers and what worked best for them through the Cottage Supervisor.
-they had team meetings once a month where they talked about every client and the Cottage Supervisor was a part of this meeting.
-the therapist reviews goals and gets the progress of goals from staff and will update the treatment plans.
-they had a milieu review every week, all direct care staff participate, and they reviewed each client during the meeting and the minutes were available to staff on the home drive as well.
-the milieu review was how staff got updates, and learned about each client.
-clients were able to find glass because windows get broken, they get cleaned up, but as clients walk around campus they find different items to pick up.
-" ...we can only police it so much, kids find things."
-a "Yoke" was part of the TCI initiation process for a RI.
-he described "It's how you get in position...step one of the restrictive intervention...hands on...to get in position..."
-staff would "...approach from behind...for

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standing...staff would come from behind to hold arms and then move into restrictive intervention..."
-when a client was head banging, he looked at what's causing this, reach out to nursing, use head boards, or something soft; they were trying to get away from using hands.
-they called it a "caring gesture;" there was a fine line with head banging and how long they could let it go on.
-" ...sometimes physical touch is used as a grounding thing; if I am upset, let me know you are there."
-they currently had a couple of clients threatening to kill staff/peers; no one was currently on a special staffing situation, or assigned a one-on-one staff.
-at the beginning of shift, staff designate a point person to focus more on a particular client.
-expectations of staff were to be in "eyesight and earshot at all times when they are out of the room."
-"I believe [Client #1] would be on eyesight, it would be documented in email, [clinician name] would indicate that."
-incident reports - supervisor team reviews them, how something may have worked and try to help staff with their documenting.
-the Quality Assurance committee looked at incidents quarterly. They did not look at strategies for each individual.
-incidents were randomly pulled as a peer review and various staff were asked to review them and give input.
-when asked about the frequency of incidents for Client #1 - " ...would be in team minutes, if something specific to that student, emailed to staff."
-they staffed Client #1 on 5/8/21 and saw this trend and initiated strategies and revisited it about

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a month later.
-they looked at it from a bigger perspective. They had been trying certain interventions; tried to determine what was working and what was not working.
-they would usually get a lot of insight from processing with the client; "...but [Client #1] is lower functioning..."
-they had been looking to transition Client #1 to another program for " ...a bit."

Interviews with the Clinician on 6/17/21, 6/24/21, and 6/30/21 revealed:
-she was not aware of the movie that triggered the client because it was too violent.
-she did not give input on what the 2nd shift did for activities.
-she felt it was an inappropriate movie for the entire milieu.
-she has told staff it was important to have opportunities to do real life things, for example had Client #1 mop floor and provide information why work regulates their mood.
-she and the case manager had conversations during the last team meeting addressing that "we are a therapeutic plan and everything we do has to have a therapeutic component...not something we discuss every week but talk about it regularly."
-staff decided what activity the clients' did in the afternoons and evenings.
-the Cottage Supervisors might have a role but she was not sure.
-she felt giving the client scissors would have been ok, "if he was in a safe space, in common area...what head space was he in, a lot of factors would be involved in that decision."

This deficiency is cross referenced into 10A NCAC 27G.1701 Scope (V293) for a Type A1 rule violation for serious neglect and must be

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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. This Rule is not met as evidenced by: Based on record reviews and interviews, the	V 112		

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facility failed to develop and implement effective goals and strategies to meet the client's needs affecting 1 of 3 clients audited (Client #1). The findings are:

Review on 6/16/21 of Client #1's record revealed:
-admitted 12/23/20.
-17 years old - identified as a transgendered male.
-diagnoses of Post-Traumatic Stress Disorder, Major Depressive Disorder with psychotic features, Generalized Anxiety Disorder with Obsessive-Compulsive features, Gender Dysphoria, Specific Learning Disorder and Attention-Deficit Hyperactivity Disorder.

Review on 6/16/21 of Client #1's Comprehensive Clinical Assessment (CCA) dated 12/9/20 with updates of 4/19/21, 4/23/21, 5/3/21 and 5/11/21 revealed:
-he was admitted from a Psychiatric Residential Treatment Facility (PRTF).
-history of sexual abuse, parental divorce, and incarcerated household member.
-history of self-injurious behaviors, poor insight and control over emotions; had not engaged in self-harm for over a month.
-he continued to need assistance in coping skills for hallucinations, depression and anxiety.
-had displayed significant progress with decline in Suicidal Ideations/Self-Injurious Behaviors (SI/SIB) in PRTF.
-5/11/21 - most recent CCA update - demonstrated the following behaviors since admission to Reuter - daily self-harm to include: cutting self with paper or fingernail, carving name of abuser onto stomach with fingernail, head banging, leaving the cottage without permission and walking around campus, property destruction to include breaking windows, suicidal ideations,

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violence towards staff in the form of biting, hitting and kicking.
-required 1-1 support to regulate.
-experiencing nightmares and flashbacks - he referred to as "voices."
-recently beginning to refuse therapy.
-as of 5/10/21 - his ability to remain safe appears to be more difficult.
-reported suicidal thoughts that he "just wants to die."
-"...had difficulty partnering with staff and clinical providers to identify ways to support her to reduce self-harm ...currently demonstrates behaviors that are more appropriate for a PRTF level of care, which is the current recommendation."

Review on 6/16/21 of Client #1's Person-Centered Profile (PCP) dated 12/9/20 and updated 1/11/21, 2/2/21, 3/1/21, 4/6/21, 5/13/21 and 6/11/21 revealed:
-12/9/20 -goals: 1. Exhibits poor impulse control and 2. History of SI/SIB.
-6/11/21 - most recent update - goal: 1. "...Struggles to manage flashbacks and emotion regulation...will demonstrate an improvement in trauma symptoms..."
-"...will practice the use of mindfulness activities once each shift as a way to decrease [his] flashbacks with the assistance of staff and clinician...will practice using effective communication skills with [his] mom with the assistance of clinician during family therapy sessions..."
-How (Support/Intervention) -"...will participate in assessments to help with treatment planning and identification of strengths, triggers, and preferred coping skills. Participate in individual, family (if applicable), and group therapies. Attend and participate in Child and Family Team Meetings....utilizing co-regulation with staff along

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with self-regulation when planning safety goals with [him]. [Client #1] will be encouraged to utilize disengagement from situations that aren't in-line with [his] treatment goals. Staff will utilize proactive check-ins for [Client #1] in order to develop healthy coping skills in an effort to decrease flashbacks."
-How continued: "Level III Residential with planned use of restrictive intervention: ...Provide recreation and exercise opportunities such as basketball, football...use of exercise room/gym. Provide therapeutic daily schedule/routine to reduce arousal levels, and prepare students for transitions..."
-goal: 2. Struggles with depressive symptoms - "...demonstrate an improvement in mood regulation as evidenced by the following:...will continue to use writing as a way to process [his] emotions and then share them during individual therapy sessions for guidance in reframing negative cognitions...."
-How - same as first goal with addition of "...[Client #1] will be encouraged by staff to utilize co-regulation and staff support surrounding the regulation of [his] mood. Staff will ask [Client #1] to be mindful of boundaries with staff in order for [him] to get [his] needs met. Staff will provide [Client #1] praise for sharing truthful stories to staff and peers and provided with feedback in [his] attempts to discuss [his] trauma during inappropriate settings."
-How continued: "...Level III staff will assist [Client #1] with mood regulation as evidenced by: leadership roles in the cottage, praise for appropriate group sharing, staff co-regulation, redirection from peer crisis, feedback about their treatment progress, and goal centered check-ins. Staff will provide a minimum risk schedule and cottage environment to assist [Client #1] in [his] processing ability and peer relations."

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-There were no specific strategies to address the difficulty of staff and clinical partnering to identify ways to support the client in reducing self-harm.
-The client's self-harm of head banging and cutting continued and escalated to property destruction, hitting and kicking staff.
-Strategies to support the client and staff during times the client was triggered by his mom were not identified.
-Alternative strategies were not provided when the client identified the gym/weight barn were triggers.
-Strategies were not developed to address the identified need that 1-1 support was required to regulate the client.
-Strategies were not developed to address the client when he began to refuse therapy.

Review on 6/16/21 of Client #1's Crisis Prevention and Intervention Plan initially dated 12/9/20 and last revised on 6/11/21 revealed:
-"What are some events or situations that have caused me trouble in the past?...I get triggered when people touch me."
-3/1/21 - Triggers: topic of safety, his abuser, being bored, feeling unsafe when returning home, staff not paying attention to him.
-4/6/21 - Triggers: topic of safety or needing to be safe. "...[He] has reported that the gym and weight barn are triggers, not receiving attention by preferred staff or check-ins from preferred staff."
-5/13/21- "Banging [his] head as a form of stress relief...Fabricating stories. Glorifying self-harm. Talking about self-harm in the common area. Will refuse to process incident or will process very superficially...pick up objects from outside and report [he] will kill [himself] with the object. Will refuse to process with non-preferred staff."
-6/2/21 - Triggers: peers in crisis, phone calls with

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mom, over stimulated when given too much or too little attention, seeing preferred staff give other peers attention, internalizing and/or imitating other peers' crisis situations.

-"What are the early warning signs that I am not doing well?... (Prevention and Early Intervention Strategies) I run to my room and isolate myself. I shut the door. I stop talking."
-3/1/21 - Strategies: "Presenting a firm schedule with alternatives if [he] doesn't like an activity. Appealing to [his] interests. Using humor and real talk work well."
-4/6/21 - Strategies: "Making a plan, providing distractions, redirection and caring gestures."
-5/13/21 - Strategies: Allow to set own goals for safety. Provide neutral staff and hold firm expectations. Provide positive feedback.
-6/2/21 - Strategies: Proactive check-in with preferred staff, one-on-one attention, give specific invitations to participate in activities, challenge some of his stories.

-"If I am in crisis, what are ways that others can help me and how can I help myself? What strategies do not work well for me? Staff should talk to me in a calm way. Remind me of my family and that they think I am important. If I have to be restrained, I prefer women...I don't like to be touched when I am upset."
-3/1/21 - Strategies: "Being around [him] but not talking until [he] is ready for a check-in."
-4/6/21 - Strategies: Humor, role playing with staff.
-5/13/21 - no strategies listed.
-6/2/21 - Strategies: one-on-one attention, make plans for check-in and safety.
-"Additional strategies for [client] can be found in the following documents: Clinical Case review minutes, Multi-disciplinary treatment team

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V 112	Continued From page 18 minutes, Direct care staff shift notes, Child and family treatment team meeting minutes, Individual Crisis Management Plans, and incident reports." Review on 6/17/21 of Individual Crisis Management Plans (ICMP) for Client #1 from March 2021 to present revealed: -meetings held 3/17/21, 4/2/21, 4/28/21, 5/5/21, 5/8/21, 6/3/21, 6/5/21, 6/10/21 and 6/15/21. -issues/triggers identified: "...Mother, being called [birth name], talking about safety or needing to be safe. [Client #1] has reported that the gym and weight barn are triggers, not receiving enough attention by preferred staff or receiving check-ins from preferred staff...", phone calls with mom, and peers being in crisis. -high risk behaviors identified: self harming, head banging, picking at skin, scratching, writing name of abuser on head and arms, "flashbacks," raising voice, rapid and loud transitions, isolating in room, defiance, name calling and screaming, attempting to open window, attempting to trigger peers, tear at staff clothing, attempting to cut staff or self with cardboard from puzzle box or pieces of glass, ingesting soap and broke markers to self -harm, running out of cottage, breaking window, threatening and instigating peers; opening window or side door triggering the alarm, breaking window, drawing several pictures depicting guns and shooting people and voiced his plan to kill peers, staff, his mom and himself. -strategies identified: make a plan, provide distractions, redirection and caring gestures, neutral staff, silence with "proximity" (being around him but not talking until he is ready), humor, role playing with staff, surprise him with a random saying, "...support screams (going outside and screaming), temperature changes for grounding (warm wash cloth), running laps...." one-on-one attention, set expectations and then	V 112		

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disengage, use "real talk", provide firm expectation, provide with options so can feel sense of control, set clear consequences and then let him make decision, physical touch (i.e. tapping back, hand pressure on back, wedging body between client and wall to prevent head banging), allow him to paint a staff hand/arm, disengage during crisis and have a side conversation that he will want to engage in, remove the audience by separating him from the milieu, proactively ensure safety by managing the environment, and offer positive feedback when client discloses SI/HI to staff or clinician rather than harming others.
-there were no strategies to address the gym and weight barn, his mom and not liking to be touched that were identified triggers.

Review on 6/18/21 of Child and Family Team (CFT) Meeting Minutes from March 2021 through May 2021 revealed:
-meetings held on 3/1/21, 4/6/21, and 5/13/21.
-strategies identified: corrective logic, keep in eyesight when unsafe behavior demonstrated, ask for help with a task, and provide leadership opportunities.
-5/13/21 - struggles to remain safe, behavior increasing, revisit transition plan to PRTF.

Review on 6/18/21 of Clinical Case Review notes from 3/10/21 through 6/2/21 revealed:
-meetings on 3/10/21, 4/7/21, 5/5/21, and 6/2/21.
-how/interventions: support walk, activities during day, staff tell him they like spending time with him and encourage him to demonstrate appropriate behaviors, exaggerated praise, lowering expectations, and challenge to use coping skills by asking him to write a song about it.

Review on 6/21/21 of Residential Multidisciplinary

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Team Meetings for Client #1 from March 2021 through May 2021 revealed:
-meetings on 3/30/21, 4/20/21 and 5/18/21.
-restrictive interventions and self-harm incidents reviewed.
-alternatives identified: short term goals were "...somewhat effective..." depending on his "head space" at the time, structured activities that allowed client to have staff's attention - he preferred 1-1 staff.

Review on 6/18/21 of Special Staffing's for Client #1 dated 5/10/21 and 6/8/21 revealed:
-5/10/21 Reason for Special Staffing: Client #1 had gradual increase in acuity through self-injury behaviors, property destruction, and running behavior.
Identified Triggers: "Everything with Mom, Inconsistency with mom-lies and support. Talking to mom, or feeling like mom is avoiding [him]. Feeling unwanted by mother. Not being recognized to the degree [he] feels is necessary. The word Safety."
Preventative Strategies: same as mentioned in all the above documents.
-6/8/21 - Reason for Special Staffing: Concerns of self-injurious behaviors. Thirty day follow-up meeting to determine appropriate strategies and transition plan.
Preventative Strategies: "The strategies above are still relevant and working... Staff call mom before hand and discuss the current space of [Client #1] to support the phone call and avoid triggering a crisis."
-mom was an identified trigger as early as 3/17/21.

Review on 6/15/21, 6/16/21, 6/17/21, 6/22/21, 6/23/21, and 6/24/21 of facility Incident Reports (IR), facility Level III Restrictive Intervention

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Incident Reports (RI) and the North Carolina Incident Response Improvement System (IRIS) for Client #1 from March 2021 to June 2021 revealed:
-incidents continued with mom being his trigger; 18 from 3/4/21 through 6/10/21.
-the client continued to be taken to the gym/weight barn after he identified this as a trigger.

-3/4/21 8:12 p.m. IR- Self injurious- head banging on concrete wall in his room, threatened to open window.
Trigger: phone with mom calling client by his legal name.
Ways to manage the identified trigger to prevent future incidents: Staff can continue to work on support plan prior to calling mother, clinician can speak with mother to further support plan.

-3/18/21 8:25 p.m. IR- Self-injurious. Client scratched his arm, head banged on a concrete wall in his room, threatened, scratched, kicked and pushed staff.
Trigger: family situation, feeling like mom doesn't care.
To prevent: talk with clinician about having conversation with mother about communication with client.

-3/19/21 5:00 p.m. IR- Self-injurious. Head banged in room on concrete wall, and tried to open window.
Trigger: by "internal family situations."
To prevent: proactive check-in between activities, and clinician getting in contact with guardian (mom).

-3/20/21 12:30 p.m. IRIS- Self injurious. Head banged in room for close to 30 minutes. Sent to

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V 112	Continued From page 22 hospital due to prolonged head banging. Triggers: client identified internal thoughts bothering him but would not disclose specifics to staff. To prevent: by communication with clinical to get in contact with mother. -3/20/21 7:00 p.m. IRIS -RI Escalation episode lasting approximately 2 hours. Client head banging. Client was physically restrained 3 times during this incident. Triggers: Mom visited this day - update to treatment plan recommended. Ways to manage the identified trigger to prevent future incidents: by providing one-on-one staffing to keep client engaged. -3/21/21 10:00 a.m. IRIS - RI Client head banged. Did not respond to attempted interventions. Triggers: mom not answering phone, and him not getting enough attention - update to treatment plan recommended. Ways to manage the identified trigger: proactive check-ins during or after each activity and inviting him to play cards. -3/24/21 7:36 p.m. IR- Self injurious. Client scratched self with soap dispenser. Triggers: phone call with mom who called him by his legal name. To prevent: create a plan before starting a call with mom. -3/27/21 1:02 p.m. IRIS -RI Client head banged against concrete wall. Triggers: did not want to watch movie (Hunger Games) saying it was too violent. Ways to manage the identified trigger: "Proactive alternate activity during non-preferred blocks."	V 112		

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-3/29/21 7:20 p.m. IR- Head banged and ran out of cottage.
Trigger: staff redirecting client from having journal in common area; anniversary of friends anniversary; a peer off task.
Client stated he was stressed and confused because mom was supposed to visit but cancelled again.
To prevent: staff should refrain from offering support walks while peers were off task.

-3/30/21 8:00 p.m. IRIS -RI Client was head banging in his room. He refused to stop. Proximity, caring gesture, physical outlets, staff support, real talk, open-ended questions, coping skills, and prompts were all ineffective.
Triggers: voices and flashbacks.
Ways to manage the identified trigger: proactive check-ins, separate from milieu when he becomes escalated.

-4/2/21 11:40 a.m. IR- Self injurious. Client scratched his arm with a broken marker cap, attempted to scratch stomach, and ingested soap.
Triggers: Client having intrusive thoughts of peer who died by suicide; per client the identified trigger was lack of attention from preferred staff.
To prevent: manage the restroom; provide positive and consistent feedback for healthy behaviors.

-4/6/21 8:42 p.m. IRIS -RI Threatened to kill self, attempted to open window, ran out of cottage, and head banged.
Triggers: Client identified hearing voices, wanting to kill himself when hears voices, losing control over his life, mom having guardianship when he turned 18.
Environmental effects: it was less structured due

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to it being "choice time."

-4/12/21 7:50 p.m. IRIS -RI Head banged, ran out of cottage, threatened to kill self. Client was physically restrained 2 times during this incident.
Triggers: client upset his mother did not visit when she said she would, feeling lied to by mom.
Ways to manage: provide a structured activity outside client's room until at baseline.

-4/14/21 3:00 p.m. IR- Self injurious. Client expressed wanting to die, scratched self with rock/stick and head banged.
Trigger: student identified feeling controlled by mom.
To prevent: staff will continue to provide proactive check-ins and encourage client to use coping skills.

-4/15/21 7:00 p.m. IR -Self injurious. Head banged on ground.
Trigger: phone call with mom. Update to crisis plan recommended.
To prevent: staff will switch out with preferred staff for neutral staff upon escalation.

-4/29/21 6:00 p.m. IR- Self injurious. Head banged in room, wanted to choke self, attempted to open window.
Triggers: staff holding firm expectations while completing chores while waiting for a phone call after his peer; client identified feeling anxious to go home and almost being 18.
To prevent: proactive support and redirect to alternative preferred activities when client requests were unable to be facilitated.

-4/30/21 6:40 p.m. IRIS -RI Client threw cups of water at staff, grabbed trays and pots to hit staff, began to grab staff's radios, keys and clothing

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items. Grabbed staff arms and choked staff.
Triggers: client not able to call mom on-time, staff split doing a room search.
To prevent: staff to manage with proximity and proactive engagement.

-5/7/21 5:30 p.m. IRIS -RI Scratched arms with sticks and rocks, attempted to open cottage, ran from the cottage, head banged on brick wall and inside on concrete wall. Client was not receptive to behavior support techniques.
Triggers: not having constant one-on-one staff support; debriefing of incident indicated client drained emotions about mom and not wanting to go home.
To prevent: set mini-motivator to check in with preferred staff.

-5/8/21 1:00 p.m. IR- Self injurious. Head banged on concrete wall, attempted to open window, and ran from cottage.
Trigger: client wanting preferred staff support; student stated trigger was his brain telling him to hurt himself.
To prevent: discuss with clinician how to best support client in setting appropriate boundaries with staff and advocating to check-in with them.

-5/8/21 8:10 p.m. IRIS -RI Client was in gym and began head banging. This continued once in room, and he also kicked window at front door of cottage and broke it.
Trigger: client stated when he was in gym he talked with staff about another peer and he was getting escalated. Staff identified trigger as client finding out Mother's Day was tomorrow.
Environment effects: having unlocked cottage enabling client to go outside and less staff available. Preferred staff was helping other peers which was triggering. "There were multiple

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V 112	Continued From page 26 non-consistent staff on the floor." Update to treatment plan recommended. To prevent: continue to assist client in making support plan for self-supporting blocks. -5/9/21 12:02 p.m. IR- Self injurious. While in gym, client claimed he was lightly tapping his head, continued head banging in cottage, attempted to open window, ran from cottage through front door. Trigger: client identified mom not answering phone consistently as trigger; staff identified client struggles during less structured activities like choice and lunch/movie. To Prevent: Staff to discuss with clinician how to best support client. Update to crisis plan recommended. -5/23/21 4:30 p.m. IR- Self-injurious. In gym, client head banged and this continued in his room. Trigger: staff identified a phone call with mom as well as less structured blocks during schedule when preferred staff stepped off floor; client identified being upset about his brother being bullied at school and hearing voices, and staff suggesting "support walks" and advocated for them to say "flower picking." To prevent: during unstructured blocks, staff can manage by proactive check-ins to make a plan and proximity to ensure follow through. -5/29/21 4:25 p.m. IR- Self injurious. Client head banged in room, walked out of the cottage, kicked windows, and hit brick wall. Trigger: client started day in "unusually bad mood"; client expressed bad phone call with mom as trigger. To prevent: staff will be very mindful of this behavior possibly occurring when client has	V 112		

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phone calls with mom.

-6/1/21 4:00 p.m. IR- Self injurious. Client threw water at staff, attempted to hit his staff, punching wall, walked out of cottage.
Trigger: client identified peer walking out of gym, and peer playing triggering song
To prevent: staff monitoring songs more closely that are being played in common area. Redirecting client when someone else gets triggered.

-6/2/21 5:35 p.m. IR- Self injurious. Client was in the gym and picked at wound on foot, punched wall. In the cottage, he was "weaponing forks, grabbed pen, ran outside."
Trigger: client identified being in negative head space from start of shift and a peer talking about Father's Day.
To prevent: staff proactively monitoring for potential triggers from peers, keeping kitchen managed, removing the audience.

-6/5/21 12:45 p.m. IRIS -RI Client was in the gym - isolated self, and said he was head banging. In cottage, he head banged on the wall and floor.
Triggers: Client's point of view: he felt sad and overwhelmed; referenced his mom, brother, abuser, and friends. Staff identified trigger as client not having preferred staff attention. He was annoyed with a peer while in the gym.
To prevent: continue proactive support and options for client. Brainstorm ideas with clinician on how to encourage client to seek positive attention from staff.

-6/5/21 1:30 p.m. IR-Self injurious. Cut self with glass, head banged on wall and floor.
Trigger: staff identified client being triggered by his peers in common area; not receiving

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preferred staff attention; being in escalated state for multiple hours. The description identified him being frustrated by a phone call. Crisis plan update recommended.

-6/10/21 11:30 a.m. IRIS - Client drew 9 pictures of nooses and guns illustrating him killing two staff, three peers and himself. He also drew himself, staff, and peers in the hospital in critical condition with the names of staff and peers. The clinician checked-in with client who confirmed he intended to harm staff, peers and himself. It was determined an Involuntary Commitment was necessary and client was transported to hospital by police.
Incident prevention: "Mediation and separation from the group when conflict occurs."

Review on 6/17/21 of a Contact Log and Nursing Report dated 6/10/21 and 6/12/21 revealed:
-6/10/21- Client #1 was approved for Involuntary Commitment (IVC) and police arrived to take client to the hospital.
-6/12/21 - returned from the hospital with no new orders or discharge summary; called hospital to obtain information and they reported Client #1 was not in their system.

Review on 6/28/21, 6/29/21 and 6/30/21 of Clinical Service Notes (individual and family therapy) for Client #1 from 3/3/21 through 6/10/21 revealed:
-there was no reference for a support plan, guidance or brainstorming with the client and staff to use prior to client calling his mom referenced in the 3/4/21, 3/24/21, 5/8/21, 5/9/21, and 6/5/21 incidents as ways to prevent future incidents.
-incidents of self-injurious behaviors continued of being triggered by mom, by mom's calls, mom not answering the phone, or mom not coming to

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visit when scheduled on 3/4/21, 3/18/21, 3/19/21, 3/20/21, 3/21/21, 3/24/21, 3/29/21, 4/6/21, 4/14/21, 4/15/21, 4/29/21, 4/30/21, 5/7/21, 5/9/21, 5/23/21, 5/29/21 and 6/5/21.

Interview on 6/15/21 with Client #1 revealed:
-he denied ever being physically restrained.
-he tried to run; "...get mad so typically I try and run away but always come back, just campus wide."
-staff always knew when he ran because alarms went off or they saw him.
-the staff ran after him, try to talk to him, he denied they put hands on him.
-his goals were "to go home, safety is involved in that, I stay safe most of the time ... draw my emotions."
-he admitted safety issues were "cutting...maybe 1 time a week...haven't done it since Thursday."
-when questioned about head banging, he said "...only ever done it once...haven't done it since.
-he denied ever having to go to the hospital as a result of hurting himself.

Interviews with the Clinician on 6/17/21, 6/24/21, and 6/30/21 revealed:
-she has "definitely seen" Client #1's behavior which included self-harm, superficial cutting and head banging.
-his behavior had "always been there but it is increasing."
-he has shifted to no longer wanting to use strategies that once worked.
-she checked-in with Client #1 to address his self harm/suicidal ideation but did not complete notes for these "check-ins."
-staff knew Client #1 was on eyesight via email and the Cottage Supervisor would communicate this face-to-face.
-she was aware the weight barn and gym were

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triggers for Client #1; she discussed this with him but couldn't determine if it was the "space or something that happened within those spaces that were triggers."
-staff took client outside of weight barn when he was triggered.
-staff discussed engaging client in another activity rather than going to the weight barn or gym but alternate activity depended on the number of staff available to do this; she was not sure that would have been possible.
-she was aware another trigger for client was being touched; she gave staff information about Client #1's triggers.
-it was "always a discussion to be having" if a client should be restrained or not.
-the goal of SI/SIB was removed from the client's treatment plan in response to "something that came up during another licensure or something about goals."
-the goal was individualized to address flashbacks; "flashbacks are typically what cause self-harm and if we can get a hold on flashbacks, we can get a hold of other behaviors... there is direct correlation between flashbacks and self harm...flashbacks of the trauma and hearing these voices of the specific people who abused him."
-within the first two weeks of admission, she created the individualized goals based on what staff/clinician notices, feedback from team meeting, and what the client reported.
-she then sent the goals to the staff in an email.
-she was responsible for updating goals.
-updates to strategies to address behaviors "usually go in the ICMP, may not write goal, but will update ICMP...so any staff coming into cottage would know."

Review on 7/1/21 and 7/2/21 of a copy of the

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V 112	Continued From page 31 recording provided by the facility revealed excerpts of the following: -on 7/1/21 - surveyor notified facility of a Type A1 rule violation in the areas of scope with cross references in competency of paraprofessionals, assessment and treatment plans and training in restrictive interventions. -a Plan of Protection (PoP) for immediate actions in these areas was requested. -the Chief Executive Office (CEO), Chief Operations Officer (COO), PQI (Performance and Quality Improvement) Director, Clinical Director, and Residential Director were present. -surveyor requested at this time if there was more information regarding the areas of non-compliance the facility would like to provide this would be accepted and reviewed prior to exit. -asked if had one-on-one staff assigned - CEO - "Oh not like an individual service provider, no we don't do that unless we are in a seriously dangerous situation, this means having someone doing a support walk with him...not 1:1 assignment...let's clear that up." -surveyor gave examples of restrictive interventions that were not determined to be as such; anything that restricts the client's movement. -COO - "We have kept [Client #1] safe this entire time...we have kept him alive...we have kept him secure within his own body with him being transgender, no other PRTF will take him but he is at imminent risk with us...is that what you are saying?" This deficiency is cross referenced into 10A NCAC 27G.1701 Scope (V293) for a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 112		

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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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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 record reviews and interviews, the facility failed to ensure services were designed to minimize the occurrence of behaviors related to functional deficits and ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint affecting 1 of 3 clients audited (Client #1). The findings are:

Cross Reference: 10A NCAC 27G.0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (V110) Based on record reviews and interviews, 2 of 3 staff (Cottage Supervisor and Residential Director) failed to demonstrate the knowledge, skills and abilities required by the population served.

Cross Reference: 10A NCAC 27G.0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (V 112) Based on record reviews and interviews, the facility failed to develop and implement effective goals and strategies to meet

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the client's needs affecting 1 of 3 clients audited (Client #1).

Cross Reference: 10A NCAC 27E.0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (V537) Based on record reviews and interviews, facility staff (Director of Residential Services) failed to demonstrate competency in the proper use of restrictive intervention procedures.

Review on 7/1/21 of the Plan of Protection dated 7/1/21 written by the Chief Executive Officer revealed:

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

"Effective @ 1PM today in response to this request for a POP, the following immediate actions have been completed. [Client #1] will have a staff dedicated during waking hours to monitor this student. [Client #1] will also have support walks as requested, unless there is a safety reason why this cannot occur. During sleeping hours all staffing and safety protocols will be maintained.
A risk assessments of [Client #1] and all other students on campus within residential services to include EAC [Eliada Assessment Center] and Reuter students were completed at 1PM.
Following this initial assessment, to further ensure safety, additional risk assessments will be completed following any concerning behaviors.
With risk assessments that indicate concern, the clinician will contact the Clinical Director and immediately implement appropriate safety measures.
In addition to the risk assessments to further ensure safety and monitor for any changes in

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safety levels, clinical check ins will be conducted daily with each student and 2 times per day with [Client #1]. During weekend hours the onsite supervisor will conduct these check ins and report any concerning findings to the clinician on call.
In addition to the items identified above the agency will maintain current protocols to include wanding students upon entry and exit of day treatment services, managing the common area each shift for items that could be utilized for self injurious behavior, and managing student rooms for any hidden items.
In addition to medication administration, nursing will conduct daily wellness checks with the students in each cottage.
On call leadership to include clinical staff, residential leadership staff and senior staff are available to staff by phone or come to campus 24/7.
All nursing staff, cottage staff, clinical staff and case managers in addition to expanded and senior leadership will be notified today July 1 by 5PM of the enhanced safety protocols to include clinical check ins, risk assessments and nursing wellness rounds.
Daily call scheduled between PQI [Performance and Quality Improvement] and Residential to monitor safety protocols and update strategies as needed."

Describe your plans to make sure the above happens.

"Layered levels of oversight will occur each day to include review of daily clinical check in forms by the PQI Director, risk assessment reviews by the Clinical Director, follow up on daily wellness checks by Nursing Manager, and Residential Leadership to check in with cottage leadership daily to assess students and any need for special

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staffing.
Senior Leadership will meet weekly to review all identified items in this plan to ensure compliance."

Review on 7/2/21 of a revised Plan of Protection dated 7/2/21 written by the Chief Executive Officer revealed:

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

"Effective @ 1PM today July 1, 2021 in response to this request for a POP, the following immediate actions have been completed. As of July 1, 2021 [Client #1] will have a staff dedicated during waking hours to monitor (defined as constant eyes on and proximity supervision of student by assigned Residential Counselor) (cottage staff). The cottage shift lead will be responsible to ensure this occurs each day. [Client #1] will also have support walks as requested, unless there is a safety reason why this cannot occur. During sleeping hours all staffing and safety protocols will be maintained.
A risk assessments of [Client #1] and all other students on campus within residential services to include EAC and Reuter students were completed at 1PM on July 1, 2021. Following this initial assessment, to further ensure safety, additional risk assessments will be completed following any concerning behaviors- (defined as any behavior that compromises the safety of the student to include self harm or harm to others). With risk assessments that indicate concern (as defined above), the clinician will contact the Clinical Director and immediately implement appropriate safety measures.
"In addition to the risk assessments to further ensure safety and monitor for any changes in

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V 293	Continued From page 37 safety levels, clinical check ins (a series of questions to assess current levels of safety) will be conducted daily by a Licensed Therapist with each student and 2 times per day with [Client #1]. During weekend hours the onsite cottage supervisor will conduct these check ins and report findings to the clinician on call. In addition to the items identified above the agency will maintain current protocols in place prior to today's date of July 1, 2021 to include wanding students upon entry and exit of day treatment services, managing the common area each shift for items that could be utilized for self injurious behavior, and managing student rooms for any hidden items. In addition to medication administration, nursing has been conducting and continues as of today July 1, 2021 daily wellness checks with the students in each cottage. On call leadership to include clinical staff, residential leadership staff and senior staff are available to staff by phone or come to campus 24/7. Support Staff is available within 15 minutes, residential leadership can be on campus as quickly as 15 minutes, senior leadership are available within 30 minutes, clinical staff could be on campus within 15 minutes. Members of Clinical and senior leadership staff are on call 24/7 365. All nursing staff, cottage staff, clinical staff and case managers in addition to expanded and senior leadership were notified yesterday July 1 by 5PM of the new enhanced safety protocols as of July 1, 2021 to include daily documented clinical check ins, and risk assessments. Daily call scheduled between PQI and Residential to review safety protocols and update strategies as needed. The PQI Director and PQI Coordinator will meet weekly to review trends, patterns and risks	V 293		

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related to incidents including restrictive interventions effective July 2, 2021.
We will identify any intervention that restricts the movements of students in any way will be identified in our documentation as a restrictive intervention and reported to all required bodies including any caring gesture that restricts movement in any way.
The treatment plan is written and updated within the CFT [Child Family Team] with all partners to include family members, the student, Care Coordinator if assigned, Guardian Ad Lietum if assigned, DSS [Department of Social Services] if involved, Eliada CM [Case Manager] and Clinician and implemented by Case Managers, Clinicians, and Residential staff of Eliada Homes. Between monthly treatment plan updates, interventions and strategy updates can be found in the CCR [Clinical Case Reviews], MDT [Multi-disciplinary Team], Team Meeting minutes, shift notes, nursing report, and Individual Crisis Management Plan (ICMP). Staff are made aware of any updates the debrief that occurs between shifts, update emails, team minutes.
If a student identifies a trigger related to a particular activity on campus to include recreation spaces, cottage staff will identify coping strategies with the student and/or identify alternative activities to participate in.
Prior to movie time, staff will review potential triggers from a movie with students to ensure they are comfortable watching the movie. Staff will provide alternative activities to the movie to support their engagement needs.
Clinicians meet with students individually for their individual therapy in addition to time spent with them with the equine program at which time the clinician works with the students on their self-identified goals for their PCP [Person-Centered Profile]. Clinicians also provide

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group therapy to support students receiving treatment for their identified goals. Clinicians are in constant contact via email and meetings to update staff on any new triggers, symptoms, and supports."

Describe your plans to make sure the above happens.

"As of July 1, 2021, layered levels of oversight will occur each day. Review of daily clinical check in forms for completion by the [PQI Director], MPA, risk assessment to be reviewed by the [Clinical Director] LCMHC, review of daily wellness checks completion by [Nursing Manager], RN, and [Residential Director], or [Assistant Residential Director], to check in with Cottage Supervisor Team daily to assess students and any need for special staffing.
Senior Leadership to include [Chief Executive Officer], [Chief Operations Officer], will meet weekly to review all identified items in this plan to ensure compliance."

Reuter Cottage is a 6 bed Residential Treatment facility that is Staff Secure for Children or Adolescents. Diagnoses included: Post-Traumatic Stress Disorder, Major Depressive Disorder, Generalized Anxiety Disorder with Obsessive-Compulsive features, Gender Dysphoria, Specific Learning Disorder, Attention-Deficit Hyperactivity Disorder, and Unspecified Trauma and Stressor Related Disorder. Client #1, 17 years old, had a history of sexual abuse, self-injurious behaviors, poor insight, hallucinations, and needed assistance with coping skills. His behaviors since being at the facility included head banging against a concrete or brick wall, cutting himself with plastic, glass, and fingernails, leaving the cottage without

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V 293	Continued From page 40 permission, breaking a window, pushing, hitting, and kicking staff, to recently drawing pictures depicting homicidal and/or suicidal ideations of staff, peers, his mom and himself. Triggers identified were anything having to do with his mom, going to the gym/weight barn, and being touched. There were no strategies to address the inability of staff and clinician to partner in managing these triggers. Staff continued to take the client to the gym/weight barn where he had 5 additional incidents of head banging and self-harm, 2 of which ended in a restrictive intervention. Added to his plan was to provide a physical touch as a way to calm him after the client identified he did not like to be touched when he was upset. Strategies to prevent future incidents were to be proactive and have planned activities of interest for the client. This would also give the client 1-1 attention that was proven to be an effective prevention of incidents. There was no proactive planning for the client during activities he did not prefer, and he did not receive 1-1 attention on a planned or consistent basis. He told staff he did not want to watch a movie that he felt was too violent. Directly after an incident of head banging, leaving the cottage and having to be physically restrained, staff brought him back to watch the end of the movie. The client was escalated after a phone call with his mom, and began head banging. Just after the client had calmed down, he was handed a pair of scissors to cut a bracelet off his ankle. The client struggled to give the scissors back. As a result of the client's triggers not being managed his behaviors continued to escalate to the point of having to be physically restrained, thus touched, 11 times during the above timeframe. When the client attempted to leave the facility either by the window or the doors he was prevented from moving by staff blocking him. He had his	V 293		

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V 293	Continued From page 41 arms/hands held when he was attempting to self-harm. These techniques restricted the client's movements but were not identified as restrictive interventions. The continued action of putting Client #1 in situations that were either identified by him and/or by the facility as triggers and not planning strategies to manage this constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2,000 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 293		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is	V 537		

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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 (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.

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(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 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;

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(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.
(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.

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V 537	Continued From page 45 This Rule is not met as evidenced by: Based on record reviews and interviews, facility staff (Residential Director) failed to demonstrate competency in the proper use of restrictive intervention procedures. The findings are: Review on 6/16/21 of Client #1's record revealed: -admitted 12/23/20. -17 years old - identified as a transgendered male. -diagnoses of Post-Traumatic Stress Disorder, Major Depressive Disorder with psychotic features, Generalized Anxiety Disorder with Obsessive-Compulsive features, Gender Dysphoria, Specific Learning Disorder and Attention-Deficit Hyperactivity Disorder. Review on 6/15/21, 6/16/21, 6/17/21, 6/22/21, 6/23/21, and 6/24/21 of facility Incident Reports (IR) for Client #1 revealed: 3/18/21- staff used strategic proximity to keep client from rejoining peers in common area until he could be safe for 2 minutes. 4/2/21- strategic proximity used to block marker cap from scratching client's skin. 5/8/21- staff blocked client's door to his room as he attempted to go in; and blocked windows as he tried to climb out. 5/9/21- multiple attempts to block client from leaving cottage; client had to make a plan before he was allowed to leave his room. 5/23/21- client would have to make a plan before leaving the support room. 5/29/21- provided grounding technique of holding the client's hands which continued until client handed over scissors.	V 537		

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-none of the above incidents were documented as restrictive interventions.

Review on 6/11/21 and 6/15/21 of Client #2's record revealed:
-admitted 2/26/21.
-13 years old.
-diagnoses of Unspecified Trauma and Stressor Related Disorder, Cannabis Use Disorder, Amphetamine Type Substance Use Disorder, and Major Depressive Disorder.

Review on 7/6/21 of incident reports from March 2021 through June 2021 for Client #2 revealed:
3/28/21- staff tried to cover client's forearm to prevent her from scratching.
5/4/21- staff used caring gesture of holding client's arms when client scratched her legs harder.
-none of the above incidents were documented as restrictive interventions.

Review on 6/15/21 of excerpts from the TCI (Therapeutic Crisis Intervention) Student Workbook provided by the Residential Director revealed:
-Behavior Support Techniques: caring gesture, redirection and distractions, proximity, managing the environment, prompting, hurdle help, directive statement, and time away.
-Caring Gesture - "...Nonverbal expressions of caring include a pat on the arm or a quick hug...."
-Redirection and distractions - "...involves turning a young person's attention away from an undesirable or inappropriate activity...redirection is asking the child to go to a different activity, not redirecting them back to the same activity that was causing the stress..."
-Proximity - "...means nearness...moves closer to the young person who is struggling to stay in

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control...touch is a powerful intervention and, if used at the wrong time by the wrong person, can easily escalate the situation. Any use of touch should be done before the child escalates and within the context of a trusting and therapeutic relationship...The use of touch requires knowledge of how the young person will interpret the touch...A young person who has been sexually assaulted may misperceive the intentions of a touch....It is also very important never to touch a young person who has escalated beyond irritation to anger. This will more often than not escalate the situation...."

Interview on 6/11/21 with Staff #1 revealed:
-if Client #1 wanted us to leave him alone, we have to remind him to "show us some safety."
-if he continued to get aggressive, and not showing safety, we have to do a restrictive intervention.
-if he was trying to leave she would put herself between the client and the door to block him from leaving.
-she was not sure if this was a part of TCI technique, but when she was trying to get Client #1 (not sure of date), staff tried to use blocking technique, with the help of the Cottage Supervisor, and then he ended up having to be restrained.

Interviews on 6/11/21 and 6/23/21 with Staff #2 revealed:
-she had not had to use a restrictive intervention on anyone for over a year.
-if Client #1 attempted to open a door or window to leave she would not block him and allow him to leave.
-restrictive interventions were not planned, but if client was a danger to himself or others she would have to initiate one.

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Interview on 6/24/21 with Staff #3 revealed:
-she had not used a restrictive intervention on Client #1; they do not see as many behaviors on the 1st shift.
-when client's self-harmed "heavily," scratching at arms, or legs she would try to distract him/her verbally or take his/her hands and gently redirect them.
-physical touch was the most effective - like putting her hand on the arm of the client.
-this was not considered a restrictive intervention.
-if the client was cutting, would want to take the object away; but mostly she would try distractions.
-if the client was trying to get out the door or a window she would use a protective stance (standing with palms open).
-if the client was attacking her she would have to weigh the risk of her getting hurt vs. the client leaving.
-if you know that client has never left campus, sometimes it was safer to let the client walk out.
-if someone is going off campus or engaging in dangerous behavior may have to initiate a restrictive intervention, but never plan it.
-restrictive intervention was the last option.

Interview on 6/24/21 with the Cottage Supervisor revealed:
-it was never a plan to restrain a client, sometimes it had to be done for safety reasons.
-the front door was never blocked if a client was trying to leave; she would stand in front of the side door to prevent the client from going out because an alarm went off when it was opened.
-if a client was really trying to get out, she was not going to stop them.
-we just talked about this yesterday in team, we don't do blocks, we stand in front of the door in a

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non-threatening way.
-we have used a lot of staff from the PRTF building and they do things a little differently.
-when asked about training for the PRTF staff coming to the level III cottage - "theoretically it's in a pre-service."
-if the staff do not know what interventions may or may not be used she will sit down with that staff and use the minutes from their team meetings to teach them about clients' and possible interventions to be used.
-she described body blocking as staff standing with their arms down and palms facing up.

Interviews on 6/16/21, 6/17/21 and 6/24/21 with the Residential Director revealed:
-his role was to oversee the staff and supervisors of all residential programs.
-he was also one of the TCI trainers.
-when a client was head banging, we look at the front end, what's causing this, reach out to nursing, we use head boards, or something soft, trying to get away from using hand.
-we call it a caring gesture; there is a fine line with head banging and how long we can let it go on.
-" ...sometimes physical touch is used as a grounding thing, if I am upset, let me know you are there."
-if a client was trying to exit, and staff blocked the doorway, this was not a restrictive intervention.
-this was not a restrictive intervention since the client had 3 other directions they could go.
-if the client kept trying to exit and pushed staff, would depend on what pushing looked like, if aggressive, would initiate a restrictive intervention.

This deficiency is cross referenced into 10A NCAC 27G.1701 Scope (V293) for a Type A1 rule violation for serious neglect and must be

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