

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL0601263</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/07/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>JASPER'S HOUSE DAY TREATMENT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2311 VILLAGE LAKE DRIVE</b> <b>CHARLOTTE, NC 28212</b>
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V 000	INITIAL COMMENTS  A follow up and complaint survey was completed on 9-7-21. The complaint was substantiated (#NC00179804). Deficiencies were cited.  This facility is licensed for the following service category: 10A NCAC 27G 1400 Day Treatment for Children and Adolescents with Emotional or Behavioral Disturbances.	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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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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V 108	<p>Continued From page 1</p> <p>reporting, investigating and controlling infectious and communicable diseases of personnel and clients.</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure that one of one audited staff (Staff #1) was trained to meet the needs of the clients as specified in the client's treatment/habilitation plan. The findings are:</p> <p>Review on 8-17-21 and 8-23-21 of Staff #1's personnel record revealed: -Hire date of 1-4-2021. -No documentation of any client specific training.</p> <p>Review on 8-16-21 and 8-23-21 of Client #1's record revealed: -Admitted 9-29-20. -11 years old. -Diagnoses include; Post Traumatic Stress Disorder (PTSD), Disruptive Mood Dysregulation Disorder (DMDD), Physical Child abuse (victim). -Assessment dated 9-22-20 revealed: "would be happy and pleasant one moment and be angry and hostile the next...has become verbally aggressive in her school environment and has been frequently asked not to come back due to her aggressive behaviors...little insight into coping skills and learning to self-regulate her emotions...appears to be more invested in getting her own way...becomes escalated she threatens the adult around her...her mother would frequently slam her head into a wall when she</p>	V 108		

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V 108	<p>Continued From page 2</p> <p>was 4-5 years old...when [Client #1] realizes a placement is not equipped to handle her needs she tends to become very destructive and angry towards caregivers. This is when her behavior escalates and she becomes very threatening, intimidating, and aggressive towards the adults in her life...struggles with appropriate emotional self-regulation and lashes out when angered...threatens to damage property when she is escalated and hurt others physically."</p> <p>-Person Centered Plan dated 1-1-21 revealed: "What 'works'- stay calm, loving, humor, music, art, being gentle, soft spoken, making things fun and engaging...what 'doesn't work'- ignoring her, being escalated around her, yelling...within the past 60 days [Client #1] has continued daily mood swings, including crying spells, anger outbursts including verbal and physical aggression (slap/punch/push foster sister in home, physical fights with male students at day treatment center), property damage...non compliance, suicide behavior/threats...history of multiple hospitalizations and PRTF (Psychiatric Residential Treatment Facility) due to aggressive/bizarre behaviors...", Goals include: "will work on improving overall behavior and managing a healthy lifestyle...As evidenced by; Being able to express anger in a productive manner without destroying property or personal belongings, being free of threats to self and others...learning to accept personal responsibility for own actions, being respectful of adults and avoid talking back...How; Day treatment will; ...Monitor peer interactions and redirect any negative behavior. Teach [Client #1] how to read and respond to social cues appropriately. Teach [Client #1] how her actions affect others and vice versa. Teach [Client #1] how to disengage from peer conflict in an appropriate way. Teach and model healthy boundaries. Role model socially</p>	V 108		

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V 108	<p>Continued From page 3</p> <p>appropriate behavior." Crisis Plan includes; Early warning signs: withdrawn, quiet, may be short in responses, may also become agitated. Avoiding a crisis early on; likes to draw and color. She likes to go outside. Distractions/shifting gears. Allowing her to vent and then redirect. If in a crisis what works; "What 'works'- stay calm, loving, humor, music, art, being gentle, soft spoken, making things fun and engaging....what 'doesn't work'- ignoring her, being escalated around her, yelling...Continued education for everyone involved on how trauma has impacted [Client #1] and being understanding that she struggles trusting adults and others."</p> <p>Review on 8-17-21 of Client #2's record revealed: -14 years old. -Diagnoses include; Attention Deficit/Hyperactivity Disorder (ADHD), Adjustment Disorder with mixed anxiety and depressed mood. -Assessment dated 2-12-21 revealed: Recommend day treatment, exhibits bizarre behavior, yelling, cussing, and laughing unprovoked. Triggered by auditory hallucinations, increasingly disruptive in school, steals things from home.</p> <p>Review on 8-17-21 of Client #3's record revealed: -Admitted 7-20-21. -11 years old. -Diagnoses include; DMDD, PTSD, Attention Deficit/Hyperactivity Disorder (ADHD) combined type, Autism Spectrum Disorder (provisional.) -Psychological Evaluation dated 3-22-21 revealed; Struggles with inattention, hyperactivity, social skills, behaviors, anxiety and atypicality. Struggles with sensory issues, social delays and executive functioning deficits.</p>	V 108		

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V 108	<p>Continued From page 4</p> <p>Review on 8-17-21 of Client #4's record revealed: -14 years old. -Diagnoses include: ADHD, Major Depressive Disorder, PTSD. -Comprehensive Clinical Addendum dated 10-12-20 revealed: one year in day treatment with minimal progress, continues to display difficulty regulating emotions with several instances of instigating fights with peers, significant verbal aggression, recommendation client reside in level III setting.</p> <p>Review on 8-17-21 of Client #5's record revealed: - 13 years old. -Diagnoses include: ADHD, PTSD, DMDD, Unspecified Disruptive Impulse Control and Conduct Disorder. -Assessment dated 4-6-21 revealed: "Displays high risk aggressive behaviors weekly ...punching holes in walls ...2-8-21 filled nerf gun with construction nails and shot them around the room (home) with his young cousin and 11 year old sister in room ...past 30 days been hospitalized twice ...broke front windows with a rock ...4-15-21 throwing things, cursing at police admitted to hospital then also after he was discharged threatened aunt with stolen machete ... ..threatened to kill family in their sleep ...recommend level III."</p> <p>Review on 8-17-21 of undated/unsigned write up about the incident on the van on 7-28-21 revealed: -"On July 28, 2021 at approximately 2:30 pm [Qualified Professional/Director] received a phone call indicating [Client #1] was spiraling out of control and the van driver (Staff #1) needed some assistance at [address]. At that time, I [Qualified Professional] and [Qualified Professional/Director] drove to the location where the incident occurred.</p>	V 108		

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V 108	<p>Continued From page 5</p> <p>When we arrived at the address provided [Client #1] was upset and hit the windshield with the mailbox of [address]. The windshield had already been broken with something from a local construction area down the street from where the van was parked. [Qualified Professional/Director] got out of the car and was able to approach [Client #1] if she could calm down and tell her what transpired. [Client #1] was still crying but willing to get in the car with myself and [Qualified Professional/Director]. [Client #1] reported she was upset and called the driver a 'B'. [Client #1] stated she started hollering at the other students in the van as well. It was reported that the driver pulled over to get [Client #1] to calm down. [Client #1] continued to escalate and wanted to get off the van. [Client #1] picked up a crowbar (tire iron) that was underneath one of the seats and attempted to hit driver. Driver apprehended the crowbar (tire iron). [Client #1] reported to [Qualified Professional/Director] and myself that the crowbar (tire iron) hit her in the stomach. [Qualified Professional/Director] looked at her stomach and there were no bruises or marks. [Client #1] stated the van driver (Staff #1) jacked her up causing her to rip her shirt. [Client #1] stated that made her very angry so she pushed past the driver and begin to walk up the street. [Client #1] stated she hit the windshield and was prepared to hit anyone who came towards her. The driver did call the police and all parties waited until the police arrived to gather statements. Once they arrived, they began asking everyone involved questions. At that time [Client #1] and the van driver provided the police with their side of the incident. Once all parties gave their information [Client #1] was transported to her after school program at [After School Program]."</p> <p>Interview on 8-16-21 and 8-30-21 with Client #1</p>	V 108		

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V 108	<p>Continued From page 6</p> <p>revealed:</p> <ul style="list-style-type: none"> <li>-She had been at the facility approximately one year.</li> <li>-When asked about the incident on the van: "Well I got a little upset, I broke the windshield but that's what happened I normally don't ride that van, I rode it that day the other van driver had an appointment."</li> <li>-She pulled up a sign and a plastic mailbox and broke the windshield on the van.</li> <li>-"I really, really don't want to talk about this."</li> <li>-She refused to talk about Staff #1.</li> <li>- Staff #1 cursed at her and deliberately pushed the tire iron into her stomach,</li> <li>-Client #1 reported that Staff #1 told her she was going to "f**k her up."</li> <li>-She does not talk with Staff #1 now.</li> </ul> <p>Interview on 8-23-21 with Client #2 revealed:</p> <ul style="list-style-type: none"> <li>-She had been on the van the day of the incident.</li> <li>-Two other clients were "playing around" and Client #1 "got mad and said she was getting off."</li> <li>-Client #1 tried to get off the van, Staff #1 tried to stop her, but Client #1 spit on her.</li> <li>-The other clients got off the van for safety.</li> <li>-Client #1 got off the van, bit one of the other clients and grabbed "something."</li> <li>-Client #1 got something from a nearby construction site and broke the windshield of the van.</li> <li>-The other clients had gotten back on the van by then.</li> <li>-The police were called.</li> <li>-Client #1 did pick up a tire iron and try to hit Staff #1.</li> <li>-"The driver (Staff #1) grabbed the crowbar (tire iron) and took it from her."</li> <li>-She did not see the tire iron hit Client #1, but Client #1 said that it had.</li> </ul>	V 108		

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V 108	<p>Continued From page 7</p> <ul style="list-style-type: none"> <li>-She didn't see Staff #1 grab Client #1's arm or hear Staff #1 ask the other clients to get Client #1 back on the van.</li> <li>-She never heard Staff #1 cursing.</li> <li>-Staff #1 did try to talk to Client #1 but Client #1 would not listen.</li> </ul> <p>Interview on 8-23-21 with Client #3 revealed:</p> <ul style="list-style-type: none"> <li>-Client #1 became upset and started cursing.</li> <li>-He did hear Staff #1 cursing also "but she didn't mean it in a mean way, she was trying to calm her (Client #1) down."</li> <li>-Client #1 was trying to get out of the van.</li> <li>-"She was being very aggressive, she got mad and cussed."</li> <li>-Staff #1 said: "Don't talk like that."</li> <li>-Staff #1 "said the N (n****r) word, and the B (b***h) word and the A (A*s) word."</li> <li>-Staff #1 grabbed Client #1 by the arm.</li> <li>-He never saw Client #1 with a tire iron.</li> <li>-Client #1 broke the windshield of the van, she threw a mailbox, and her bookbag.</li> <li>-"She (Client #1) wasted a lot of time."</li> <li>-He did hear Staff #1 trying to calm Client #1 down.</li> </ul> <p>Interview on 8-23-21 with Client #4 revealed:</p> <ul style="list-style-type: none"> <li>-Client #1 was cussing because she wanted to sit in the front seat.</li> <li>-"She got mad and said she was getting out."</li> <li>-Staff #1 stopped the van and Client #1 went to the construction site that was there and got a sign and threw it at the windshield.</li> <li>-Client #1 also threw a mailbox at the windshield.</li> <li>-Staff #1 did try to calm her down by talking to her.</li> <li>-Staff #1 did grab Client #1's arm.</li> <li>-He never saw a tire iron.</li> <li>-He never heard Staff #1 cursing</li> </ul>	V 108		

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V 108	<p>Continued From page 8</p> <ul style="list-style-type: none"> <li>-He tried to help and told Client #1 to get back in the van, but Staff #1 had not asked him to do that.</li> <li>-"Nobody put hands on her except the driver (Staff #1)."</li> <li>-Client #1 never complained about her stomach being hurt.</li> </ul> <p>Interview on 8-23-21 with Client #5 revealed:</p> <ul style="list-style-type: none"> <li>-He was joking with another client and Client #1 became angry and cursed at him.</li> <li>-"I got upset, I told her (Client #1) to shut up. She really got upset."</li> <li>-Client #1 asked Staff #1 if she could get out, was told no, so Client #1 tried to get out while the van was still moving.</li> <li>-Staff #1 pulled the van over and again told Client #1 that she couldn't get out.</li> <li>-Staff #1 then got the other clients off the van because Client #1 was "starting to get very mad."</li> <li>-They were in a calm neighborhood and there was not a lot of traffic.</li> <li>-Client #1 got out of the van and the others clients got back in.</li> <li>-Client #1 started punching and kicking the van from the outside.</li> <li>-Client #1 broke a mailbox and tried to throw it at Client #5.</li> <li>-Client #1 then went to the construction site and got a sign. She hit the van windshield and broke it.</li> <li>-The police came. Client #1 still did not calm down.</li> <li>-"Then that's pretty much all."</li> <li>-He did see Staff #1 grabbing Client #1 by the arm. "She was grabbing her by her arms and stuff. She was just pulling her arm."</li> <li>-This was the first time Client #1 had an incident on the van like this.</li> <li>-He never heard Staff #1 curse or threaten</li> </ul>	V 108		

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V 108	<p>Continued From page 9</p> <p>Client #1. "She kept her cool."</p> <p>Interview on 8-23-21 and 8-30-21 with Staff #1 revealed:</p> <ul style="list-style-type: none"> <li>-She drives one of the vans for the facility.</li> <li>-She has driven Client #1 before, "that's my baby."</li> <li>-She was not aware of Client #1's diagnoses, her treatment plan, or her crisis plan.</li> <li>-She was supposed to receive training, but she never did.</li> <li>-She and Client #1 had bonded through music.</li> <li>-She has also been coached by the Qualified professional/Director in using a calm tone of voice.</li> <li>-She has observed other people working with Client #1 in the facility and that was how she learned.</li> <li>-"Keep them occupied so they wouldn't get upset. I learned a lot from that incident (on the van)."</li> <li>-Client #1 had not been having a good day the day of the incident.</li> <li>-"I don't allow them to curse in the van. [Client #1] seemed to be very rebellious, she used the B (b***h) word multiple times."</li> <li>-They were not far from the facility when Client #1 started kicking the seat.</li> <li>-"This was my first experience her acting that way. I said 'talk to me.'"</li> <li>-"I stopped van, I got out and went to the door asked what was wrong. I told her she had to calm down she didn't want to hear it. She wanted to get out I told her 'no.'"</li> <li>-Client #1 was getting aggressive and continued to try to get out of the van, Staff #1 was blocking the door.</li> <li>-The van was still running because it was a hot day so she wanted the air conditioning to</li> </ul>	V 108		

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V 108	<p>Continued From page 10</p> <p>remain on.</p> <p>-She (Client #1) tried to force herself out. She was cussing me. I said 'what? It's me why are you doing this?' She was kicking and tousling. I got her down the way she was tousling she was trying to kick her way out."</p> <p>-Client #1 then picked up the tire iron for the van. Staff #1 took it from her and threw it out of the van.</p> <p>-The other clients had gotten off the van for their safety.</p> <p>-Staff #1 looked out and thought one client was missing.</p> <p>-"I see one kid missing I said '[Client #1] I can't do this with you.'"</p> <p>-Staff #1 was holding Client #1 down to prevent her from getting off the van.</p> <p>-Client #1 started spitting on people, so Staff #1 let her go.</p> <p>-Client #1 then spit on the other clients so Staff #1 got the other clients back in the van.</p> <p>-She then called the Qualified Professional/Director, who called the police.</p> <p>-"I didn't touch the girl no more. After that she went to the construction and got a sign. I wasn't going to leave her. She got a pole and threw it at the window. Then she broke the mailbox. She bit a kid, spit on them. Tried to hit me with the mailbox, she was very aggressive."</p> <p>-"I should have bribed her with something, that's the only thing I didn't do. I have never experienced anything like this. This is the first incident I have had with any of the kids. When they do get upset, I can calm them down."</p> <p>-The police came and took her statement and Client #1 left with the Qualified Professional/Director.</p> <p>-She did take the tire iron from Client #1 but doesn't know if it hit the client in the stomach or not.</p>	V 108		

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V 108	<p>Continued From page 11</p> <p>Interview on 8-23-21 with Qualified Professional revealed:</p> <ul style="list-style-type: none"> <li>-She and the Qualified Professional/Director were at the office when they got a call from Staff #1 saying Client #1 was having a "major episode."</li> <li>-When they got to the scene, Client #1 had a mailbox and was attacking the van.</li> <li>-They got her to calm down, and the police came and took everyone's statement.</li> <li>-Client #1 told her that she grabbed a crowbar (tire iron) and when Staff #1 tried to take it from her, she might have gotten hit in the stomach. Client #1's stomach was checked and there were no bruises or marks.</li> <li>-Client #1 was upset because she had wanted to sit in a different seat.</li> <li>-Client #1 had never had any incidents on the van prior to this one.</li> <li>-She (Client #1) got out of the van and got a sign and broke the windshield. She then got the mailbox and that was when they arrived.</li> </ul> <p>This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type B Imposed rule violation</p>	V 108		
V 109	<p>27G .0203 Privileging/Training Professionals</p> <p>10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS</p> <p>(a) There shall be no privileging requirements for qualified professionals or associate professionals.</p> <p>(b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served.</p>	V 109		



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V 109	<p>Continued From page 13</p> <p>Personnel Requirements (V108) Based on record review and interview the facility failed to ensure one of one audited staff (Staff #1) was trained to meet the needs of the clients as specified in the client's treatment/habilitation plan. The findings are:</p> <p>Interview on 8-16-21 and 8-30-21 with the Qualified Professional/Director revealed:</p> <ul style="list-style-type: none"> <li>-Client #1 was "a handful."</li> <li>-"She is very demanding ."</li> <li>-Client #1 will grab fire extinguishers, a broom, "whatever she can."</li> <li>-Client #1's last foster parent had to discharge her because she was aggressive to the other kids in the house and also the family dog.</li> <li>-"The foster parent said she threatened to burn the house down."</li> <li>-Client #1 got aggressive on the van. She walked down the street to a construction site and got a sign. She broke the windshield of the van then got a mailbox and threw that at the van.</li> <li>-Staff #1 called her and the Qualified Professional and they both went to the site where they brought her back to the facility.</li> <li>-The police did come and take statements from everyone.</li> <li>-She did not think about training the van drivers in all the clients crisis plans and diagnoses.</li> <li>-She had only thought about the NCI (North Carolina Interventions) and first aid and CPR (cardio pulmonary resuscitation) training.</li> <li>-She hadn't wanted her van drivers to have any preconceived ideas about the clients.</li> <li>-She likes to move forward after an incident and doesn't like the clients to have to dwell on them.</li> <li>-She would make sure that all staff are trained the same way from now on.</li> </ul>	V 109		

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V 109	<p>Continued From page 14</p> <p>Plan of Protection #1 dated 9-2-21 and signed by the Qualified Professional/Director revealed:What immediate action will the facility take to ensure the safety of the consumers in your care? " [Qualified Professional/Staff #2] will discuss with them how to diffuse a situation effective today. They will have an in depth conversation on how to interact with them in all settings. This will be effective 9-2-21. In addition [Clinical Director] will schedule training today to be completed within 2 weeks."</p> <p>Describe your plans to make sure the above happens.</p> <p>"This will be effective 9-2-21."</p> <p>Plan of Protection #2 sent for Qualified Professional/Directors email 9-3-21 revealed:</p> <p>What immediate action will the facility take to ensure the safety of the consumers in your care? Effective "9-2-2021 Staff was given a brief training on what to do to defuse situations that arise on the van while transporting their students. The training on yesterday was to ensure each driver understood the triggers of clients they are transporting. They were given a CIP (Crisis Intervention Plan) on each consumer they transport. In addition to meeting with each client to see what their personal triggers are. Staff also implemented assigned seating to ensure clients were not sitting next to peers that may trigger them. ARJ (licensee) QA/QI (Quality Assurance/Quality Improvement) Director is also putting in place additional trainings for all staff to understand cultural competency as well as being aware of mental health diagnoses. [Clinical Director]</p>	V 109		

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V 109	<p>Continued From page 15</p> <p>(Clinical Director) will conduct trainings and utilize outside resources as well. Trainings are set to be completed by September 18 2021."</p> <p>Client #1 had diagnoses that included PTSD and DMDD. She could become aggressive and could damage property. Clients #2-5 also had diagnoses including PTSD, DMDD and ADHD. On 7-28-21 Client #1 became upset while riding the van, forcing Staff #1 to stop the van. Client #1 got off the van, went to a nearby construction site and got a sign. She then attacked the van and broke the windshield. She also tore a mailbox off of the post and hit the van with that. Staff #1 had not been trained in the strategies in Client #1's crisis plan to remain calm and soft spoken. It was the responsibility of the Qualified Professional/Director to ensure that staff were trained before working with the clients. The Qualified Professional/Director had not wanted the van drivers to have preconceived ideas about the clients and their behaviors. This deficiency constitutes an Impose Type B rule violation. An administrative penalty of 200.00 per day is imposed for failure to correct within 45 days.</p>	V 109		
V 366	<p>27G .0603 Incident Response Requirments</p> <p>10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</p> <p>(a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by:</p> <p>(1) attending to the health and safety needs of individuals involved in the incident;</p> <p>(2) determining the cause of the incident;</p>	V 366		

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V 366	<p>Continued From page 16</p> <p>(3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;</p> <p>(4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;</p> <p>(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;</p> <p>(6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and</p> <p>(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.</p> <p>(b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.</p> <p>(c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by:</p> <p>(1) immediately securing the client record by:</p> <p>(A) obtaining the client record;</p> <p>(B) making a photocopy;</p> <p>(C) certifying the copy's completeness; and</p> <p>(D) transferring the copy to an internal review team;</p> <p>(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who</p>	V 366		

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V 366	<p>Continued From page 17</p> <p>were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:</p> <p>(A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;</p> <p>(B) gather other information needed;</p> <p>(C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and</p> <p>(D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and</p> <p>(3) immediately notifying the following:</p> <p>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;</p> <p>(B) the LME where the client resides, if different;</p> <p>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting</p>	V 366		

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V 366	<p>Continued From page 18</p> <p>provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law.</p> <p>This Rule is not met as evidenced by: Based on interview and record review the facility failed to complete a level I incident report. The findings are:</p> <p>Review on 8-17-21 of unsigned/undated write up for incident on 7-28-21 revealed: -"On July 28, 2021 at approximately 2:30 pm [Qualified Professional/Director] received a phone call indicating [Client #1] was spiraling out of control and the van driver (Staff #1) needed some assistance at [address]. At that time, I [Qualified Professional/Staff #2] and [Qualified Professional/Director] drove to the location where the incident occurred. When we arrived at the address provided [Client #1] was upset and hit the windshield with the mailbox of [address]. The windshield had already been broken with something from a local construction area down the street from where the van was parked. [Qualified Professional/Director] got out of the car and was able to approach [Client #1] if she could calm down and tell her what transpired. [Client #1] was still crying but willing to get in the car with myself and [Qualified Professional/Director]. [Client #1] reported she was upset and called the driver a 'B'. [Client #1] stated she started hollering at the other students in the van as well. It was</p>	V 366		

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V 366	<p>Continued From page 19</p> <p>reported that the driver pulled over to get [Client #1] to calm down. [Client #1] continued to escalate and wanted to get off the van. [Client #1] picked up a crowbar (tire iron) that was underneath one of the seats and attempted to hit driver. Driver apprehended the crowbar (tire iron). [Client #1] reported to [Qualified Professional/Director] and myself that the crowbar (tire iron) hit her in the stomach. [Qualified Professional/Director] looked at her stomach and there were no bruises or marks. [Client #1] stated the van driver (Staff #1) jacked her up causing her to rip her shirt. [Client #1] stated that made her very angry so she pushed past the driver and begin to walk up the street. [Client #1] stated she hit the windshield and was prepared to hit anyone who came towards her. The driver did call the police and all parties waited until the police arrived to gather statements. Once they arrived, they began asking everyone involved questions. At that time [Client #1] and the van driver provided the police with their side of the incident. Once all parties gave their information [Client #1] was transported to her after school program at [After School Program]."</p> <p>Interview on 8-17-21 and 9-7-21 with the Qualified Professional/Director revealed:                      -She did have the Qualified Professional/Staff #2 do a write up after the incident.                      -They did not develop corrective measures to prevent the incident from happening again.                      -The Qualified Professional/Director stated that she should have completed an incident form but she got distracted and had not.</p>	V 366		
V 367	27G .0604 Incident Reporting Requirements  10A NCAC 27G .0604 INCIDENT	V 367		

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V 367	<p>Continued From page 20</p> <p><b>REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</b></p> <p>(a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:</p> <ol style="list-style-type: none"> <li>(1) reporting provider contact and identification information;</li> <li>(2) client identification information;</li> <li>(3) type of incident;</li> <li>(4) description of incident;</li> <li>(5) status of the effort to determine the cause of the incident; and</li> <li>(6) other individuals or authorities notified or responding.</li> </ol> <p>(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:</p> <ol style="list-style-type: none"> <li>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or</li> <li>(2) the provider obtains information required on the incident form that was previously unavailable.</li> </ol> <p>(c) Category A and B providers shall submit, upon request by the LME, other information</p>	V 367		

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V 367	<p>Continued From page 21</p> <p>obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).</p> <p>(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:</p> <p>(1) medication errors that do not meet the definition of a level II or level III incident;</p> <p>(2) restrictive interventions that do not meet the definition of a level II or level III incident;</p> <p>(3) searches of a client or his living area;</p> <p>(4) seizures of client property or property in the possession of a client;</p> <p>(5) the total number of level II and level III incidents that occurred; and</p> <p>(6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.</p>	V 367		

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V 367	<p>Continued From page 22</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to report a Level II incident report to the Local Management Entity within 72 hours of learning about the incident. The findings are:</p> <p>Review on 8-17-21 of unsigned/undated write up for incident on 7-28-21 revealed: -"On July 28, 2021 at approximately 2:30 pm [Qualified Professional/Director] received a phone call indicating [Client #1] was spiraling out of control and the van driver (Staff #1) needed some assistance at [address]. At that time, I [Qualified Professional/Staff #2] and [Qualified Professional/Director] drove to the location where the incident occurred. When we arrived at the address provided [Client #1] was upset and hit the windshield with the mailbox of [address]. The windshield had already been broken with something from a local construction area down the street from where the van was parked. [Qualified Professional/Director] got out of the car and was able to approach [Client #1] if she could calm down and tell her what transpired. [Client #1] was still crying but willing to get in the car with myself and [Qualified Professional/Director]. [Client #1] reported she was upset and called the driver a 'B'. [Client #1] stated she started hollering at the other students in the van as well. It was reported that the driver pulled over to get [Client #1] to calm down. [Client #1] continued to</p>	V 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL0601263</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/07/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>JASPER'S HOUSE DAY TREATMENT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2311 VILLAGE LAKE DRIVE CHARLOTTE, NC 28212</b>
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V 367	<p>Continued From page 23</p> <p>escalate and wanted to get off the van. [Client #1] picked up a crowbar (tire iron) that was underneath one of the seats and attempted to hit driver. Driver apprehended the crowbar (tire iron). [Client #1] reported to [Qualified Professional/Director] and myself that the crowbar (tire iron) hit her in the stomach. [Qualified Professional/Director] looked at her stomach and there were no bruises or marks. [Client #1] stated the van driver (Staff #1) jacked her up causing her to rip her shirt. [Client #1] stated that made her very angry so she pushed past the driver and begin to walk up the street. [Client #1] stated she hit the windshield and was prepared to hit anyone who came towards her. The driver did call the police and all parties waited until the police arrived to gather statements. Once they arrived, they began asking everyone involved questions. At that time [Client #1] and the van driver provided the police with their side of the incident. Once all parties gave their information [Client #1] was transported to her after school program at [After School Program]."</p> <p>Review on 8-23-21 of Police Report from Local Police Department revealed: -"On 7-28-21 at approximately 1418 (2:18 pm) officers responded to the listed address in reference to a disturbance. Upon arriving officers spoke with the witness who advised that he witnessed the suspect (Client #1) having a temper tantrum and damage the windshield with a road sign. He also advised that before that happened he witnessed the adult in the vehicle yelling and cussing at the suspect."</p> <p>Interview on 8-17-21 and 9-7-21 with the Qualified Professional/Director revealed: -She should have completed a level II incident report.</p>	V 367		

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V 367	Continued From page 24  -"I will take all the blame for that." -She got distracted the day of the incident and had not completed it.	V 367		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int.  10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or 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.	V 536		

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V 536	<p>Continued From page 25</p> <p>(g) Staff shall demonstrate competence in the following core areas:</p> <p>(1) knowledge and understanding of the people being served;</p> <p>(2) recognizing and interpreting human behavior;</p> <p>(3) recognizing the effect of internal and external stressors that may affect people with disabilities;</p> <p>(4) strategies for building positive relationships with persons with disabilities;</p> <p>(5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;</p> <p>(6) recognizing the importance of and assisting in the person's involvement in making decisions about their life;</p> <p>(7) skills in assessing individual risk for escalating behavior;</p> <p>(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and</p> <p>(9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).</p> <p>(h) Service providers shall maintain documentation of initial and refresher training for at least three years.</p> <p>(1) Documentation shall include:</p> <p>(A) who participated in the training and the outcomes (pass/fail);</p> <p>(B) when and where they attended; and</p> <p>(C) instructor's name;</p> <p>(2) The Division of MH/DD/SAS may review/request this documentation at any time.</p> <p>(i) Instructor Qualifications and Training Requirements:</p> <p>(1) Trainers shall demonstrate competence</p>	V 536		

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V 536	<p>Continued From page 26</p> <p>by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.</p> <p>(2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.</p> <p>(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.</p> <p>(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.</p> <p>(5) Acceptable instructor training programs shall include but are not limited to presentation of:</p> <p>(A) understanding the adult learner;</p> <p>(B) methods for teaching content of the course;</p> <p>(C) methods for evaluating trainee performance; and</p> <p>(D) documentation procedures.</p> <p>(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.</p> <p>(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.</p> <p>(8) Trainers shall complete a refresher instructor training at least every two years.</p> <p>(j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.</p> <p>(1) Documentation shall include:</p>	V 536		

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V 536	<p>Continued From page 27</p> <p>(A) who participated in the training and the outcomes (pass/fail);</p> <p>(B) when and where attended; and</p> <p>(C) instructor's name.</p> <p>(2) The Division of MH/DD/SAS may request and review this documentation any time.</p> <p>(k) Qualifications of Coaches:</p> <p>(1) Coaches shall meet all preparation requirements as a trainer.</p> <p>(2) Coaches shall teach at least three times the course which is being coached.</p> <p>(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.</p> <p>(l) Documentation shall be the same preparation as for trainers.</p> <p>This Rule is not met as evidenced by: Based on record review and interview one of one audited staff (Staff #1) failed to demonstrate competency in training on alternatives to restrictive interventions, effecting one of five clients (Client #1). The findings are:</p> <p>Review on 8-16-21 and 8-23-21 of Client #1's record revealed:</p> <ul style="list-style-type: none"> <li>-Admitted 9-29-20.</li> <li>-11 years old.</li> <li>-Diagnoses include; Post Traumatic Stress Disorder (PTSD), Disruptive Mood Dysregulation Disorder (DMDD), Physical Child abuse (victim).</li> <li>-Assessment dated 9-22-20 revealed: "...little insight into coping skills and learning to</li> </ul>	V 536		

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V 536	<p>Continued From page 28</p> <p>self-regulate her emotions...appears to be more invested in getting her own way...becomes escalated she threatens the adult around her....when [Client #1] realizes a placement is not equipped to handle her needs she tends to become very destructive and angry towards caregivers. This is when her behavior escalates and she becomes very threatening, intimidating, and aggressive towards the adults in her life..."</p> <p>-Person Centered Plan dated 1-1-21 revealed: " Crisis Plan includes; Early warning signs: withdrawn, quiet, may be short in responses, may also become agitated. Avoiding a crisis early on; likes to draw and color. She likes to go outside. Distractions/shifting gears. Allowing her to vent and then redirect. If in a crisis what works; "What 'works'- stay calm, loving, humor, music, art, being gentle, soft spoken, making things fun and engaging....what 'doesn't work'- ignoring her, being escalated around her, yelling...Continued education for everyone involved on how trauma has impacted [Client #1] and being understanding that she struggles trusting adults and others."</p> <p>Review on 8-17-21 of Staff #1's personnel record revealed: -Hire date of 1-4-21. -Training on alternatives to restrictive interventions (North Carolina Interventions (NCI) Plus) completed 1-8-2021.</p> <p>Review on 8-23-21 of Police Report from Local police Department revealed: -"On 7-28-21 at approximately 1418 (2:18 pm) officers responded to the listed address in reference to a disturbance. Upon arriving officers spoke with the witness who advised that he witnessed the suspect (Client #1) having a temper tantrum and damage the windshield with</p>	V 536		

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V 536	<p>Continued From page 29</p> <p>a road sign. He also advised that before that happened he witnessed the adult in the vehicle yelling and cussing at the suspect."</p> <p>Interview on 8-30-21 with Client #1 revealed: -Client #1 reported that Staff #1 told her; "I'm gonna whup your f*****g a*s if you touch me with something." -"It mad me more madder."</p> <p>Interview on 8-23-21 with Client #2 revealed: -She didn't hear Staff #1 curse at Client #1. -She did hear Staff #1 try to talk to Client #1 but Client #1 wouldn't listen.</p> <p>Interview on 8-23-21 with Client #3 revealed: -She did hear Staff #1 curse. -"She said the N (n****r) word, the B (b***h) word and the A (a*s) word."</p> <p>Interview on 8-23-21 with Client #4 revealed: -He did hear Staff #1 curse but "she didn't mean it in a mean way, she was trying to calm her (Client #1) down."</p> <p>Attempted interview on 8-24-21, 8-26-21 and 8-27-21 with the police officer who made the report were unsuccessful so no contact was made with the unnamed witness.</p> <p>This deficiency is cross referenced into 10A NCAC 27E .0108 Training in Seclusions, Physical Restraint and Isolation Time out (V537) for a Type A2 rule violation and must be corrected within 23 days.</p>	V 536		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO	V 537		

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V 537	<p>Continued From page 30</p> <p>10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(e) Formal refresher training must be completed by each service provider periodically (minimum annually).</p> <p>(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.</p> <p>(g) Acceptable training programs shall include, but are not limited to, presentation of:</p>	V 537		

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V 537	<p>Continued From page 31</p> <p>(1) refresher information on alternatives to the use of restrictive interventions;</p> <p>(2) guidelines on when to intervene (understanding imminent danger to self and others);</p> <p>(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);</p> <p>(4) strategies for the safe implementation of restrictive interventions;</p> <p>(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;</p> <p>(6) prohibited procedures;</p> <p>(7) debriefing strategies, including their importance and purpose; and</p> <p>(8) documentation methods/procedures.</p> <p>(h) Service providers shall maintain documentation of initial and refresher training for at least three years.</p> <p>(1) Documentation shall include:</p> <p>(A) who participated in the training and the outcomes (pass/fail);</p> <p>(B) when and where they attended; and</p> <p>(C) instructor's name.</p> <p>(2) The Division of MH/DD/SAS may review/request this documentation at any time.</p> <p>(i) Instructor Qualification and Training Requirements:</p> <p>(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.</p> <p>(2) Trainers shall demonstrate competence by scoring 100% on testing in a training program</p>	V 537		

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V 537	<p>Continued From page 32</p> <p>teaching the use of seclusion, physical restraint and isolation time-out.</p> <p>(3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.</p> <p>(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.</p> <p>(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.</p> <p>(6) Acceptable instructor training programs shall include, but not be limited to, presentation of:</p> <p>(A) understanding the adult learner;</p> <p>(B) methods for teaching content of the course;</p> <p>(C) evaluation of trainee performance; and</p> <p>(D) documentation procedures.</p> <p>(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.</p> <p>(8) Trainers shall be currently trained in CPR.</p> <p>(9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach.</p> <p>(10) Trainers shall teach a program on the use of restrictive interventions at least once annually.</p> <p>(11) Trainers shall complete a refresher instructor training at least every two years.</p>	V 537		

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V 537	<p>Continued From page 33</p> <p>(k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.</p> <p>(1) Documentation shall include:</p> <p>(A) who participated in the training and the outcome (pass/fail);</p> <p>(B) when and where they attended; and</p> <p>(C) instructor's name.</p> <p>(2) The Division of MH/DD/SAS may review/request this documentation at any time.</p> <p>(l) Qualifications of Coaches:</p> <p>(1) Coaches shall meet all preparation requirements as a trainer.</p> <p>(2) Coaches shall teach at least three times, the course which is being coached.</p> <p>(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.</p> <p>(m) Documentation shall be the same preparation as for trainers.</p> <p>This Rule is not met as evidenced by: Based on record review and interview one of one audited staff (Staff #1) failed to demonstrate competencies when performing a restrictive intervention. The findings are:</p> <p>Cross Reference: 10A NCAC 27E .0107 Training on Alternatives to Restrictive Interventions (V536) Based on record review and interview one of one audited staff (Staff #1) failed to demonstrate competency in training on alternatives to restrictive interventions, effecting one of five clients (Client #1).</p> <p>Interview on 8-30-21 with Client #1 revealed:</p>	V 537		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL0601263</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/07/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>JASPER'S HOUSE DAY TREATMENT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2311 VILLAGE LAKE DRIVE</b> <b>CHARLOTTE, NC 28212</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 537	<p>Continued From page 34</p> <ul style="list-style-type: none"> <li>-Staff #1 had hit her with a crowbar (tire iron)</li> <li>-Staff #1 was holding her down in the van.</li> <li>-"She was holding me with her whole body. She is really big so it really hurted me."</li> <li>-Client #1 would not elaborate on how Staff #1 was holding her down, she just kept repeating "She was holding me down."</li> </ul> <p>Interview on 8-23-21 with Client #3 revealed:</p> <ul style="list-style-type: none"> <li>-She saw Staff #1 grab Client #1's arm.</li> <li>-"She grabbed her arm and that was for awhile."</li> </ul> <p>Interview on 8-23-21 with Client #4 revealed:</p> <ul style="list-style-type: none"> <li>-He saw Staff #1 holding Client #1 by her arm. (He demonstrated holding his left arm.)</li> <li>-"Nobody put their hands on her (Client #1) except the driver (Staff #1)."</li> </ul> <p>Interview on 8-23-21 with Client #5 revealed:</p> <ul style="list-style-type: none"> <li>-"She (Staff #1) was trying to put her in the car. She was grabbing her by her arms and stuff. She was just pulling her arm."</li> </ul> <p>Interview on 8-23-21 with Staff #1 revealed:</p> <ul style="list-style-type: none"> <li>-Client #1 was "very rebellious" the day of the incident.</li> <li>-Client #1 wanted to get off the van and was told she could not.</li> <li>-Client #1 tried to get out of the van.</li> <li>-Staff #1 had stopped the van to go to Client #1 and talk to her.</li> <li>-"Now she (Client #1) was really trying to get out of the van. I was blocking the door."</li> <li>-"She (Client #1) tried to force her way out. I said, "What? It's me, why are you doing this.""</li> <li>-Client #1 then picked up the tire iron and Staff #1 told the other clients to get out of the van.</li> <li>-Staff #1 takes the tire iron away from Client #1 and throws it out of the van.</li> </ul>	V 537		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL0601263</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/07/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>JASPER'S HOUSE DAY TREATMENT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2311 VILLAGE LAKE DRIVE</b> <b>CHARLOTTE, NC 28212</b>
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V 537	<p>Continued From page 35</p> <p>-"I see one kid missing, I said, '[Client #1] I can't do this with you.'"</p> <p>-"I was holding her on the floor (of the van). I was holding her down."</p> <p>-Client #1 was laying on her back on the floor of the van, with her legs dangling out of the van.</p> <p>-"It was more body pressure. My hands were still free. I see people apply pressure. I just see them apply pressure to calm them down."</p> <p>-"She (Client #1) started trying to spit on people. I let her go. I backed up and started calling kids names and they were all there."</p> <p>-"I didn't touch the girl no more. After she went to the construction and got a sign. I wasn't going to leave her."</p> <p>-"I should have bribed her with something that's the only thing I didn't do. I have never experienced anything like this. This is the first incident I have had with any of the kids. When they do get upset, I can calm them down."</p> <p>Interview on 8-23-21 with the NCI Plus trainer revealed:</p> <p>-When asked if a staff member could hold someone down by laying on top of them she replied: "No,No,No."</p> <p>-A staff member should never use body pressure to hold a client down.</p> <p>Review on 9-2-21 of the Plan of Protection dated 9-2-21 and signed by the Qualified Professional/Director revealed:</p> <p>What immediate action will the facility take to ensure the safety of the consumers in your care?</p> <p>"We will be redoing all NCI training with all staff. Today I will have a conversation with all drivers on proper protocol when driving the students. Today prior to staff leaving here a notebook with all</p>	V 537		

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V 537	<p>Continued From page 36</p> <p>crisis plan and verbal explanation on what works best for all clients. Effective 9-2-21."</p> <p>Describe you plans to make sure the above happens.</p> <p>"This will be accomplished by 9-2-21."</p> <p>Client #1 had diagnoses that include PTSD and DMDD. She can be very destructive and aggressive when agitated. Her crisis plan states that allowing her to vent and then redirect. If Client #1 is in a crisis, to stay calm, soft spoken. On 7-28-21 Client #1 became agitated and aggressive while on the transportation van operated by the facility. Staff #1 cursed at Client #1, escalating her further. Staff #1 failed to follow de-escalation techniques in the treatment plan. Staff #1 then lay on top of Client #1 in a full body press in an attempt to prevent Client #1 from leaving the van. When Client #1 was out of the van, Staff #1 grabbed Client #1 by the arm to try to get her back in the van. This deficiency constitutes a Type A2 rule violation for substantial risk of serious harm and must be corrected within 23 days. An administrative penalty of 1500.00 is imposed. If the violation is not corrected within 23 days, an additional penalty of 500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.</p>	V 537		