STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080-216	A. BUILDING: _____ B. WING _____	R 01/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TMR RESIDENTIAL	1335 WEST RIDGE ROAD SALISBURY, NC 28147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint and follow-up survey was completed on 1/19/22. The first complaint was substantiated(Intake #179800). The second complaint was unsubstantiated(Intake #184468). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. The survey sample consisted of audits of 4 current clients.	V 000		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have	V 109		

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V 109	Continued From page 1 met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on records review, observations and interviews, the facility failed to ensure 1 of 1 Qualified Professional (QP) demonstrated knowledge, skills and abilities required by the population served. The findings are: Cross Reference: 10A NCAC 27G .0209(c) MEDICATION REQUIREMENTS V118 Based on records review, observations and interviews, the facility failed to ensure medications were administered to a client on the written order of a person authorized by law to prescribe drugs, a MAR of all drugs administered to each client was kept current and medications administered were recorded immediately after administration affecting 4 of 4 clients(#1, #2, #3 and #4). Cross Reference: 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS V296 Based on interviews and records review, the facility failed to ensure two direct care staff shall	V 109		

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V 109	Continued From page 2	V 109		

be present for one, two, three or four children or adolescents affecting 4 of 4 clients(#1, #2, #3 and #4).

Review on 1/13/22 of the QP's personnel record revealed:
-date of hire 11/12/18;
-a job description signed by the QP on 7/25/19 documented the following responsibilities: "sets clear quality requirements," "coordination of each child or adolescent's treatment plan," "improves processes and services" and "takes responsibilities for subordinates' activities;"
-documentation of all required trainings in the record.

Review on 1/18/22 of a Plan of Protection completed on 1/13/22 and 1/18/22 by the QA/QI (Quality Assurance/Quality Improvement) & Compliance Director revealed the following documented:
-"What immediate action will the facility take to ensure the safety of the consumers in your care? 10A NCAC 27G .0209 Medication Requirements (c) Administration V118 (crossed referenced into V109) --
Emergency meeting was held with Director, the Lead QP and additional QP to discuss issues relating to oversite. [01/13/22; see attached] The following will be enacted immediately:
· Lead QP will conduct immediate audit (within the next 24 hours) to include MARs/Meds/Dr Orders and submit findings to QA/QI & Compliance.
· Ongoing, Lead QP will review the MAR ' s weekly and submit a report of findings each week by Monday morning.
· Lead QP, will schedule quarterly medication review with the contracted agency pharmacist.
· Refresher medication administration training

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V 109	Continued From page 3 for all staff administering medications within the facility. Online refresher course due January 17, 2022. Facilitator, QA/QI & Compliance Director. 10A NCAC 27G .1704 Minimum Staffing Requirements V296 (crossed referenced into V109) Lead QP will ensure that residents are monitored per the staff to client ratio as outlined in the service definition. Lead QP will schedule treatment teams to discuss updating PCP to address resident ability to supervised in the community by one (1) staff. 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals V109 cited as a Type B rule violation Staff will ensure that residents are monitored per the staff to client ratio as outlined in the service definition. Lead QP will schedule treatment teams to discuss updating PCP to address resident ability to be supervised in the community by one (1) staff. QA/QI & Compliance Director will provide Lead QP and additional QP with supervision and training to address issues with competency in the areas of lack of oversight with meds/staffing requirements. Initial mtg 01/13/22 [See below scheduled dates];" -"Describe your plans to make sure the above happens. QA/QI will initiate the above actions. Lead QP and QP's will sign amended outline of staff duties to ensure understanding and for accountability. All QP's will be meeting bi-weekly with QA/QI. Procedures will be put in place to ensure coverage of the houses via rotating on-call schedule." Clients #1, #2, #3 and #4 had diagnoses which included Disruptive Mood Dysregulation Disorder,	V 109		

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V 109	Continued From page 4 Autism, Conduct Disorder, Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, Borderline Functioning Disorder and Unspecified Trauma Disorder. Clients #1, #2, #3 and #4 had a history of the following issues and behaviors: physical and verbal aggression, suicidal and homicidal ideation, self-injurious behaviors, elopement, impulsivity, poor anger management, poor peer relations, high levels of anxiety and intentional defiance of rules. On the morning of 1/4/22, one staff was working third shift with all 4 clients. On 1/4/22, the QP transported clients #2, #3 and #4 to school, took client #1 in the community and then returned to the facility alone with client #1 until second shift staff arrived around 3pm. The treatment plans of clients #1, #2, #3 and #4 did not have documentation of approved one on one staff to client ratio while in the community. The QP stated she did not know she had to put the documented approval in the treatment plans. The QP was also responsible for the oversight of the MARS for clients #1, #2, #3 and #4. There were 47 blank dosing dates, discrepancies between the MARs, the labels on the medications and the physicians' orders as well as missing physician orders for the medications Trazadone, Ibuprofen, Multivitamin, Absorbase Cream and Adapalene Gel. The lack of appropriate staffing, the issues with the medications and MARS and the lack of oversight of the medications by the QP constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients and must be corrected within 45 days. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 109		

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V 114	Continued From page 5	V 114		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire and disaster drills in a 24-hour facility were held at least quarterly and were repeated for each shift. The findings are: Review on 1/5/22 of the facility's fire and disaster drills documentation from 9/1/21-1/5/22 revealed the following: -no documented 1st shift fire drills from 9/7/21-12/30/21; -no documented 1st shift disaster drills from 9/21/21-12/30/21. Interview on 1/13/22 with the Qualified Professional(QP) revealed she was not aware of the missing first shift fire and disaster drills. This deficiency constitutes a re-cted deficiency	V 114		

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V 114	Continued From page 6 and must be corrected within 30 days.	V 114		
V 117	27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner. This Rule is not met as evidenced by:	V 117		

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V 117	Continued From page 7 Based on records review, interview and observations, the facility failed to ensure prescribed medications were properly labeled with the client's name, the prescriber's name, the current dispensing date; the name, strength, quantity, and expiration date of the prescribed drug, the name, address, and phone number of the pharmacy or dispensing location and the name of the dispensing practitioner affecting 2 of 4 clients(#1 and #). The findings are: Finding #1: Review on 1/5/22 of client #1's record revealed: -admission date of 7/10/21; -age 16 years; -diagnoses of Adjustment Disorder with Mixed Anxiety and Depressed Mood, Other Specified Trauma and Stressor-Related Disorder and Disruptive Mood Dysregulation Disorder(DMDD); -physician's order dated 7/15/21 for Previfem birth control. Observation on 1/5/22 at 11:42am of client #1's medications revealed Previfem birth control in a purple box with an expiration date of 4/2022 with no client's name, no prescriber's name, no current dispensing date, no name, address, and phone number of the pharmacy or dispensing location and no name of the dispensing practitioner. Finding #2: Review on 1/5/22 of client #2's record revealed: -admission date of 7/1/21; -age 17 years; -diagnoses of Autism, Attention Deficit Hyperactivity Disorder(ADHD), Conduct Disorder, Oppositional Defiant Disorder(ODD), Unspecified Trauma Disorder and Borderline Functioning Disorder;	V 117		

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V 117	Continued From page 8 -physician's order dated 10/4/21 for Mylan birth control. Observation on 1/5/22 at 11:07am of client #2's medications revealed Mylan birth control in a single gray monthly plastic sleeve with no client's name, no prescriber's name, no current dispensing date, no name, strength, quantity, and expiration date of the prescribed drug, no name, address, and phone number of the pharmacy or dispensing location and no name of the dispensing practitioner. Interview on 1/13/22 with the Lead Qualified Professional revealed the facility will keep the original boxes for the birth control with the labels from now on.	V 117		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The	V 118		

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V 118	Continued From page 9 MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on records review, observations and interviews, the facility failed to ensure medications were administered to a client on the written order of a person authorized by law to prescribe drugs, a MAR of all drugs administered to each client was kept current and medications administered were recorded immediately after administration affecting 4 of 4 clients(#1, #2, #3 and #4). The findings are: Finding #1: Review on 1/5/22 of client #1's record revealed: -admission date of 7/10/21; -age 16 years; -diagnoses of Adjustment Disorder with Mixed Anxiety and Depressed Mood, Other Specified Trauma and Stressor-Related Disorder and Disruptive Mood Dysregulation Disorder(DMDD); -physician's order dated 10/29/21 for oxcarbazepine 300mg(milligram) one tablet twice daily for mood;	V 118		

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V 118	Continued From page 10 -physician's order dated 12/10/21 for risperidone 0.5mg one tablet at bed for mood and aggression; -physician's order dated 12/10/21 for oxcarbazepine 300mg one and a half tablets twice daily for mood; -physician's order dated 7/15/21 for Previfem birth control. Observation on 1/5/22 at 11:42am of client #1's medications revealed: -oxcarbazepine 300mg one tablet twice daily dispensed 12/1/21 in a bubble pack medication booklet; -risperidone 0.5mg one tablet at bed for mood and aggression dispensed 12/10/21 in an individual bubble pack; -an individual bubble pack dispensed 12/10/21 with half pills in all the dosing date bubbles with a sticker documenting "7am" and a label documenting oxcarbazepine 300mg one and a half tablets twice daily; -a second individual bubble pack dispensed 12/10/21 with half pills in all the dosing date bubbles with a sticker documenting "7pm" and a label documenting oxcarbazepine 300mg one and a half tablets twice daily; -Previfem birth control in a purple box with an expiration date of 4/2022 with no label. Review on 1/5/22 of client #1's MARs for 11/2021, 12/2021 and 1/2022 revealed: -dosing dates of 12/27/21-12/31/21 and 1/5/22 left blank with no explanation on the MAR for oxcarbazepine 300mg one tablet twice daily; -risperidone 0.5mg one tablet at bed not listed on the 1/2022 MAR; -oxcarbazepine 300mg one and a half tablets twice daily not listed on the 1/2022 MAR; -dosing date of 1/5/22 at 7am left blank with no	V 118		

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V 118	Continued From page 11	V 118		

explanation on the MAR for Previfem birth control.

Interview on 1/4/22 with client #1 revealed:
-took her medications in the morning at 7am and at night at 7pm;
-not missed any medications.

Finding #2:
Review on 1/5/22 of client #2's record revealed:
-admission date of 7/1/21;
-age 17 years;
-diagnoses of Autism, Attention Deficit Hyperactivity Disorder(ADHD), Conduct Disorder, Oppositional Defiant Disorder(ODD), Unspecified Trauma Disorder and Borderline Functioning Disorder;
-physicians' orders dated 10/11/21 and 11/22/21 for oxcarbazepine 150mg one tablet twice daily for mood;
-physicians' orders dated 10/25/21 and 11/22/21 for trazadone 50mg one tablet at bed for sleep with no discontinue physician's order;
-physicians' orders dated 8/11/21 for multivitamin gummy chews 3 gummies daily and clinical antiperspirant roll-on use daily;
-physician's orders dated 10/11/21 and 11/22/21 for vyvanse 30mg one in the am for ADHD;
-physician's order dated 10/4/21 for Mylan birth control;
-physician's order dated 8/12/21 for Flonase 50mcg one spray in each nostril once daily for allergies and for Ketotifen Fumerate 0.025% eye solution instill one drop twice daily for allergies.

Observation on 1/5/22 at 11:07am of client #2's medications revealed:
-oxcarbazepine 150mg one tablet twice daily for mood dispensed 1/1/22;
-trazadone 50mg one tablet at bed for sleep

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V 118	Continued From page 12 dispensed 1/1/22; -multivitamin gummy chews 3 gummies daily dispensed 1/1/22 -clinical antiperspirant roll-on use daily dispensed 10/1/21; -vyvanse 30mg one in the am dispensed 12/3/21; -Mylan birth control no dispense date and no label; -Flonase 50mcg one spray in each nostril once daily dispensed 1/1/22; -Ketotifen Fumerate 0.025% eye solution instill one drop twice daily dispensed 1/1/22. Review on 1/5/22 of client #2's MARs for 11/2021, 12/2021 and 1/2022 revealed: -dosing dates of 1/1/22-1/3/22 and 1/5/22 in the am left blank with no explanation on the MAR for oxcarbazepine 150mg one tablet twice daily for mood; -dosing dates of 12/26/21-12/31/21 had a horizontal line drawn through with "discontinued" for trazadone 50mg one tablet at bed for sleep; -dosing date of 1/5/22 7am left blank for the following medications: multivitamin gummy chews 3 gummies daily, clinical antiperspirant roll-on use daily, vyvanse 30mg one in the am, Mylan birth control and Flonase 50mcg one spray in each nostril once daily; -dosing dates of 11/1/21-11/11/21(pm), 11/13/21-11/30/21(pm) and 1/1/22-1/5/22(am) left blank with no explanation on the MARs for Ketotifen Fumerate 0.025% eye solution instill one drop twice daily. Interview on 1/4/22 with client #2 revealed: -take her medications daily in the morning and at night; -staff did not forget to give her medications; -not missed any medications.	V 118		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 13	V 118		

Finding #3:
Review on 1/5/22 of client #3's record revealed:
-admission date of 11/17/21;
-age 15 years;
-diagnoses of DMDD, Autism and Unspecified Intellectual Disorder;
-a discharge summary from a prior provider signed by a RN(Registered Nurse) but with no physician's order for the following medications: adapalene 0.1% gel apply small amount to affected area at bedtime for acne and Absorbase Moisturizing cream apply twice daily for dry skin.

Observation on 1/5/22 at 10:53am of client #3's medications revealed:
-adapalene 0.1% gel apply small amount to affected area at bedtime dispensed 10/1/21;
-Absorbase Moisturizing cream apply twice daily dispensed 10/1/21.

Review on 1/5/22 of client #3's MARs from 11/2021, 12/2021 and 1/2022 revealed:
-no 12/2021 MAR in the record;
-no 1/2022 MAR in the record.

Finding #4:
Review on 1/5/22 of client #4's record revealed:
-admission date of 7/30/21;
-14 years old;
-diagnosis of Unspecified Trauma and Stressor-Related Disorder;
-copy of a physician's verbal orders documented by a nurse dated 9/30/21 but not signed off by the physician for multivitamin one tablet daily.

Observation on 1/5/22 at 10:57am of client #4's medications revealed multivitamin one tablet daily dispensed 1/1/22.

Review on 1/5/22 of client #4's MARs for 11/2021,

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V 118	Continued From page 14 12/2021 and 1/2022 revealed: -dosing date of 1/5/22 7am left blank with no explanation on the MAR for multivitamin one tablet daily. Interview on 1/5/22 with the Qualified Professional(QP) revealed: -QPs are supposed to review the MARs and the medications; -staff #4 also was supposed to review MARS when she gave the pm medications; -doctor said over the telephone to stop client #2's trazadone; -stated she needed to go pick up the discontinue order from the doctor; -did not know why there was not any 12/2021 and 1/2022 MAR for client #3 in the record; -looked but was not able to find the missing MARs; -not aware of the blanks on the clients' MARs. Interview on 1/12/22 with staff #4 revealed: -only there for night time medications; -give the medications out at 7pm; -not seen any blanks on the prior shift for 1st shift; -"think that the QP does that," (review medications and MARs); -"typically up to par, everyone does their due diligence to sign the MARs." Interview on 1/11/21 with the Director revealed: -she was on site with the QP at this time looking at the MARs and medications; -she reported she, the QP and the Lead QP share QP responsibilities at all the facilities; -mainly she and the QP are over this facility; -she stated the oversight of the medications at this facility are done by the QP; -she also reported staff #4 comes in and checks	V 118		

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V 118	Continued From page 15 the MARs on 2nd shift; -normally the QP looks at the MARs daily; -the QP and staff #4 look at the medications/MARs; -she looked at the medications for client #1 and saw the single bubble packs with half pills in it labeled am/pm for oxcarbazepine; -also saw client #1's MAR listed one pill twice daily and the medication booklet with one pill twice daily in it; -the QP told her the physician increased client #1's medication after the medication booklets were filled so the single bubble pack was sent by the pharmacy. This deficiency is a re-cited deficiency. This deficiency is cross-referenced into 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS V109 for Type B rule violation and must be corrected within 45 days.	V 118		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present	V 296		

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V 296	Continued From page 16 for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on interviews and records review, the facility failed to ensure two direct care staff shall be present for one, two, three or four children or	V 296		

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V 296	Continued From page 17	V 296		

adolescents affecting 4 of 4 clients(#1, #2, #3 and #4). The findings are:

Review on 1/5/22 of client #1's record revealed:
-admission date of 7/10/21;
-age 16 years;
-diagnoses of Adjustment Disorder with Mixed Anxiety and Depressed Mood, Other Specified Trauma and Stressor-Related Disorder and Disruptive Mood Dysregulation Disorder(DMDD);
-client #1 had a history of anger outbursts, aggression, self-injurious/self-harm behaviors, impulsivity. stealing and intentional violation of rules. Client #1 also displayed high levels of anxiety, depression, agitation, suicidal ideation and homicidal ideation resulting in inpatient psychiatric care. Client #1 had a history of making false allegations against caregivers and had a consensual sexual relationship with a peer in a prior placement. Client #1 also had frequent and severe conflict with peers.

Review on 1/5/22 of client #2's record revealed:
-admission date of 7/1/21;
-age 17 years;
-diagnoses of Autism, Attention Deficit Hyperactivity Disorder(ADHD), Conduct Disorder, Oppositional Defiant Disorder(ODD), Unspecified Trauma Disorder and Borderline Functioning Disorder;
-client #2 had a history of anger issues, aggression, paranoia and property destruction. Client #2 displayed crying, irritability, moodiness, attention seeking behaviors and verbal hallucinations. Client #2's behaviors resulted in past law enforcement involvement and prior inpatient psychiatric hospitalizations. Client #2 also demonstrated poor peer relations.

Review on 1/5/22 of client #3's record revealed:

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V 296	Continued From page 18 -admission date of 11/17/21; -age 15 years; -diagnoses of DMDD, Autism and Unspecified Intellectual Disorder; -client #3 had a history of defiance, verbal and physical aggression, property destruction and bizarre verbal outbursts. Client #3 displayed paranoia, poor social skills, mood instability and a lack of understanding social cues. Client #3 had a prior inpatient psychiatric hospitalization for suicidal ideation. Review on 1/5/22 of client #4's record revealed: -admission date of 7/30/21; -14 years old; -diagnosis of Unspecified Trauma and Stressor-Related Disorder; -client #4 had a history of physical aggression, elopement, impulsivity and unsafe, risky behaviors such as getting in a vehicle with a stranger and spending the night in a hotel with two unknown males. Client #4 exhibited suicidal ideation resulting in law enforcement involvement, physical threats to law enforcement with a pair of scissors and inpatient psychiatric hospitalization. Interview on 1/4/22 with client #1 revealed: -was suspended from school for 10 days before the holiday break; -at the facility all day today; -went to the library and then came back to the facility to read her books; -got up with the other clients this morning; -one staff was working; -it was staff #3; -staff #3 gave the clients their medications and fixed her and the other clients breakfast; -the Qualified Professional(QP) came in "around 8;"	V 296		

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V 296	Continued From page 19 -staff #3 left "around 8;" -the QP took the clients to school; -been here today with the QP; -staff #1 came in at 3:00pm. Interview on 1/4/22 with client #2 revealed: -staff #3 or staff #2 work third shift; -woke up this morning and staff #3 was working; -the QP took them out in the community. Interview on 1/4/22 with client #3 revealed: -woke up this morning at 6am and staff #3 was working; -the QP took them out in the community. Interview on 1/4/22 with client #4 revealed: -staff #3 was working this morning; -the school bus was late; -the QP came in and took them to school around 8am; -staff #3 or staff #2 work third shift. Review on 1/5/22 of client #1, #2, #3 and #4's treatment plans revealed no documentation of assessments to allow decreased supervision of clients while in the community. Interview on 1/7/22 with a Social Services Social Worker revealed: -popped up one day at the facility around the time school was getting out; -found one staff at the facility when the bus came; -the other staff was not there yet. Interview on 1/12/22 with the House Manager revealed: -different people work third shift; -"[staff #3] or [staff #2] typically;" -"one of them(staff #3 or staff #2) relieves me at 11pm."	V 296		

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V 296	Continued From page 20 Interview on 1/13/22 with the QP revealed: -stated she was not aware of the rule in 1700 which says it has to be in the treatment plan if a staff takes a client out in the community; -did not know she had to put this in the treatment plans. This deficiency is a re-cited deficiency. This deficiency is cross-referenced into 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS V109 for Type B rule violation and must be corrected within 45 days.	V 296		