STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL039-061	A. BUILDING: _____ B. WING _____	C 02/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF ANGELS	2187 LAUREN MILL DRIVE OXFORD, NC 27565

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and complaint survey was completed on 2/11/22. Complaint Intake (NC 00185280) was unsubstantiated. Deficiencies were cited. The facility is licensed for the following service category, 10A NCAC 27G .5600F Supervised Living for Alternative Family Living. The survey sample consisted of one Former Client. There were no current clients admitted to the facility.	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills.	V 110		

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V 110	Continued From page 1 (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure one of one staff (#2) to demonstrated knowledge, skills and abilities required by the population served. The findings are: Review on 2/4/22 of staff #2's record revealed -Alternative to Family Living (AFL) provider -Hire date of 5/1/15 Review on 2/4/22 of Former Client (FC) #1's record revealed: -Admission date of 3/15/21 and Discharge date of 1/20/22 -Diagnoses of Moderate Intellecutual Developmentally Disability (IDD), Schizoaffective Disorder-Bipolar Type, Mild Depressed Bipolar Disorder and Mixed Hyperlipidemia. -Treatment Plan dated 3/1/21 revealed, "Requires 24 hour supervision...Needs to be monitored when in the community...needs to be next to staff at all times when in the community." Review on 2/1/22 of incident report dated 1/19/22 regarding FC #1 revealed the following: "1/19/2022 5:09pm [staff #2]AFL caller [FC #1]-Member [staff #2], [FC #1] and [staff #2's grandson] was on the way to [near by city]. While	V 110		

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V 110	Continued From page 2	V 110		

in route [Staff #2] states that [FC #1] was having 'behaviors' raising his fist stating 'I will hit you and beat your MFA (explicit).' [Staff #2] states that AFL provider was on the phone to witness the behaviors in the car. This continued on the way to [nearby city]. On the way back behaviors escalated so [staff #2] reports she pulled over at an exit rest area with a restaurant. [Staff #2] states [FC #1] was yelling 'call the police.' As she was trying to get his seat belt off, [FC #1] was holding the door and beating on the window and car. He continued to escalate. [Staff #2] reports, [FC #1] then ran in the restaurant, behind the counter and hit a man in the head. [Staff #2] states he attacked the cook and was hitting the man. [Staff #2] then called the police. [Staff #2] stated that a lady in the restaurant was recording a video of the situation. The police came and [FC #1] started yelling and screaming 'don't take me.' [Staff #2] stated that the police were able to calm [FC #1]. [Staff #2] states the police documented injuries and took her and [FC #1's] information. [Staff #2] states [FC #1] has scars and blood on his lip and chin. His hand was also red. [Staff #2] states that there was no official police report filed. On-call (On call Qualified Professional) asked where they were now. All were in the car on the way home. [Staff #2] stated [FC #1] was calm and quiet now and will see if [FC #1] needs PRN (as needed) medication. Due to [FC #1] being calm, on-call declined to speak with him with hopes not to cause further distress. [Staff #2] will complete needed documentation once she is home and settled. On-call reported information to clinical manager."

Below are examples of where staff #2 failed to demonstrate competency regarding FC #1.

A. Cross Reference 10A NCAC 27E .0107

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V 110	Continued From page 3 Training on Alternatives to Restrictive Interventions (V536) Based on record review and interview the facility failed to ensure one of one staff (#2) demonstrated competency in the use of Alternatives to Restrictive Interventions. B. Cross Reference 10A NCAC 27G .5603 Supervised Living for Alternative Family Living -Operations (V291) Based on record review and interviews the facility failed to ensure services were coordinated for one of one former client (FC #1). C. Staff #2 left FC #1 unsupervised in the car while in crisis. Interview on 2/7/22 the male restaurant worker stated: -Was sitting by the window while on his break when FC #1 and staff #2 pulled into the parking lot. -Staff #2 and her grandson went into the restaurant to purchase a "to go" plate. -FC #1 remained inside the car in the parking lot alone. -Staff #2 and her grandson were in the restaurant approximately eight to ten minutes before walking back out to the car. -Saw staff #2 open the back car door and it seemed like FC #1 was kicking at the door and FC #1 jumped out and headed toward the restaurant. -FC #1 was walking really fast and looking back to see if staff #2 was following him. -FC #1 came into the restaurant crying and "very upset." D. Staff #2 allowed FC #1 to be videoed by others while in crisis.	V 110		

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V 110	Continued From page 4 Interview on 2/1/21 staff #2 stated: -On 1/19/22 FC #1 had been agitated all day, so she decided to take him for a ride to calm him down. -She along with her minor grandson and FC #1 headed to a nearby city to get their phone fixed. -While in the car, FC #1 continued to get more agitated and they decided to turn around to head home. -FC #1 was making statements that he was going to hit staff #2's grandson. -Her grandson, began to video on his cell phone FC #1 while in crisis in the back seat of the car. -On the way home, she decided to stop to pick up a plate of food to have for dinner because FC #1's behaviors were so bad she knew she would not be able to cook. -Once they stopped in the parking lot, she had to get out to open FC #1's door because she had the child safety locks on. - FC #1 jumped out of the car and ran into the restaurant, he hit a male staff in the head and attempted to go into the kitchen. -A female staff in the restaurant began to record the incident on her phone. -The female staff later sent her the video saying she recorded it "for liability purposes." Review on 2/1/22 at 10:30 AM of the videos of FC #1 on staff #2's phone recorded by staff #2's minor grandson and female restaurant worker revealed: -FC #1 was sitting in the back seat of a vehicle, with his fist drawn back stating, "I'm gonna hit you [staff #2's grandson]." -FC #1 was standing in front of the kitchen door of the restaurant with his fist drawn back saying "I'm gonna hit you." -The video played for several minutes.	V 110		

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-Interview on 2/10/22 a female restaurant worker stated:
-On 1/19/22 FC #1 came running into the restaurant crying and ran behind the counter toward their kitchen area.
-Staff #2 came in the restaurant behind him and said, "Can you record this?"
-Not sure why she wanted this recorded, but assumed it was because she was using her phone to call the police.
-Staff #2 asked her to text her the video before she left.

E. Staff #2 did not provided Law Enforcement with FC #1's information needed to respond to the crisis situation.

Review on 2/1/22 at 10:30 AM of a video of FC #1 in the restaurant revealed:
-FC #1 was standing in front of the kitchen door with his fist drawn back toward the male restaurant worker saying "I'm gonna hit you."
-The video went on for several minutes.
-Police arrived on the scene and were observed talking to staff #2 while the male restaurant worker was still trying to calm FC #1.
-One police officer asked staff #2 what were FC #1's diagnoses, and staff #2 told the police officer she could not give him that information because it was at her home and he would have to go there to get it.

Interview on 2/1/22 staff #2 stated:
-She could not provide FC #1's personal information to this police officer in front of everyone in the restaurant.
-Did not think the police officers were doing a good job when they responded, so she was concerned about giving them FC #1's information.

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V 110	Continued From page 6 Interview on 2/4/22 FC #1's legal guardian stated: -FC #1 should never be unsupervised at any time, especially during crisis. -"Surprised" FC #1 did not jump out of the car and run while he was unsupervised as he had a history of elopements. -"Not happy" with the fact that staff #2 had different people videoing FC #1. -Staff #2's minor grandson could be posting this video on social media or sharing it with friends. -This was a violation of FC #1's privacy by having others video him. -"Felt like" staff #2 failed FC #1 all around on 1/19/22. Interview on 2/9/22 the Clinical Director stated: -Staff #2 informed her that her grandson had videoed FC #1 while in the car and in crisis. -Staff #2 told her the video was of the roof of the car and only had the audio of FC #1 threatening her grandson. -Staff #2 told her the video was too large to share with her. -Staff #2 had been trained in confidentiality and should never have anyone video a client. -Staff #2 should have shared FC #1's information with law enforcement to ensure they were aware of what was going on with him. -Had not heard any of these details about the videos, stopping to get food, or FC #1 being left in the car alone from staff #2 when they discussed the incident on 1/19/22. Interview on 2/9/22 and 2/10/22 the Director stated: -They were not aware of what actually happened with FC #1 on 1/19/22 until this survey. -Staff #2 had been an Alternative Family Living (AFL) employee for many years and they never had any concerns with her.	V 110		

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V 110	Continued From page 7 -Staff #2 had told them a different story of events that occurred on 1/19/22. -Once they found out the details as of today (2/9/22), they have begun their own investigation. -Had already spoke with the male restaurant employee and they have decided to terminate staff #2's employment. -Will continue their investigation and complete the Health Care Personnel Registry (HCPR) immediately. Review on 2/10/22 of Plan of Protection dated 2/10/22 completed by the Director revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? -Effective 1/20/22 the member residing in the facility House of Angels MHL 039-061 was removed. There are currently no members in the home. United Support Services, Inc. (USS) (Licensee) has terminated the staff associated with this site. USS will be relocating the license to another site in the near future. Additional steps have been take by USS to report the findings and concerns to the HCR (Health Care Personnel Registry). Describe your plans to make sure the above happens. -The member has already been removed from the staff member care and removed from the home. The staff member was terminated on 2/11/22 and a report has been submitted to HCR (Health Care Personnel Registry). United Support Services, Inc. Director has ensured that there are existing policies, trainings and practices in place prohibiting these types of actions. The actions of the former staff member are not consistent with USS's standards and expectations and do not reflect the quality of service provided by USS."	V 110		

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V 110	Continued From page 8 FC #1 had diagnoses of Moderate Intellecutual Developmentally Disability (IDD), Schizoaffective Disorder-Bipolar Type, Mild Depressed Bipolar Disorder and Mixed Hyperlipidemia. On 1/19/22 Staff #2 took FC #1 on an outing to help reduce his agitation. Staff #2 had her minor grandson with her during this outing and he was allowed to video FC #1 in the car while in crisis on his phone. Staff #2 then decided to stop and pick up food while leaving FC #1 in the car unsupervised. for approximately ten minutes. When they returned to the car, FC #1 jumped out and ran into the restaurant crying saying staff #2 had hit him. Staff #2 stated FC #1 hit a male worker in the head and that was when she called 911. Interviews with staff in the restaurant provided a different account of the incident stating that FC #1 did not assault anyone in the restaurant and staff #2 had asked a female worker in the restaurant to video the incident. During the incident staff #2 never attempted to deescalate FC #1 or provide information to Law Enforcement when they arrived.. On 4/12/21 FC #1 had a routine cleaning at the dentist where he was found to have five cavities. Staff #2 was informed to make an appointment to get them filled. On 1/17/22 FC #1 was seen again for routine cleaning and was found to have six more cavities, now making a total of eleven cavities. Staff #2 never made an appointment to get the cavities filled. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 110		

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V 291	Continued From page 9	V 291		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure services were coordinated for one of one former client (FC #1). The findings are:	V 291		

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V 291	Continued From page 10 Review on 2/4/22 of FC #1's record revealed: -Admission date of 3/15/21 and Discharge date of 1/20/22 -Diagnoses of Moderate Intellecutual Developmentally Disability (IDD), Schizoaffective Disorder-Bipolar Type, Mild Depressed Bipolar Disorder and Mixed Hyperlipidemia. Interview on 2/1/22 staff #2 stated: -FC #1's legal guardian was "not happy" with her and was often "disrespectful" towards her. -FC #1's legal guardian was recently upset with her for not taking FC #1 to the endodontist. -The endodontist that FC #1 was referred to did not accept his insurance and she did not want to have to spend his personal money of $1500.00 dollars when she could find another endodontist that would take his insurance. -Found an endodontist that accepted FC #1's insurance, and they did not find anything wrong with his tooth. Interview on 2/4/22 FC #1's legal guardian stated: -She had issues with staff #2 providing her information for FC #1's medical records. -She would request all after visit records be sent to her so she could "stay on top" of what was going on with FC #1. -Once while reviewing FC #1's medical records, she noticed he had mulitple cavities which staff #2 had not taken him to get filled. -FC #1 also was referred to an endodontist and staff #2 gave her multiple excuses as to why this was not done. -Staff #2 told her the endodonist did not take his medicaid and she was going to find another endodontist that would. -Told staff #2 it did not matter, that he needed to	V 291		

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V 291	Continued From page 11	V 291		

be seen and she would worry about the cost.
-Initially had monthly team meetings with FC #1 and staff #2.
-Then she decided she needed to have meetings twice a month to "stay on top" of his care.
-Saw a note a few months ago on a medical record, "to see a neurologist," and staff #2 did not take FC #1 to this appointment until she told her to.
-Had not been happy with his care with staff #2 and was looking to move him prior to this incident.

Interview on 2/9/22 FC #1's dentist office stated:
-FC #1 had an appointment on 4/12/21 for a routine cleaning and was found to have five cavities.
-Staff #1 was to schedule an appointment to get those filled, but she never did.
-On 10/19/21 FC #1 was seen in the office for an "emergency appointment" due to a tooth ache.
-At that time FC #1 was referred to an endodontist.
-The endodontist FC #1 was referred to did not accept FC #1's insurance, so they referred him to another location.
-On 1/17/22 FC #1 was seen in their office for a routine cleaning and was found to have six more cavities.
-A new appointment was scheduled for 1/25/22 for fillings, but he did not show.

Interview on 2/9/22 the Qualified Professional stated:
-Had been told during a team meeting a while back that staff #2 was not following up with medical appointments.
-Had addressed this with staff #2 on the importance of reading the after visit summaries and scheduling appointments.

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V 291	Continued From page 12 -Understood there was a disagreement with staff #2 and the legal guardian but that was resolved as FC #1 was seen by the endodontist. -Not heard of any other issues with staff #2 not taking FC #1 to appointments. -Was not aware of the dental appointments where he had accumulated so many cavities in the last year. Mulitple attempts on 2/10/22 and 2/11/22 to interview on staff #2 again was unsuccessful due to her not returning calls. This deficiency is cross referenced into 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110) for a Type A1 rule violation and must be corrected within 23 days.	V 291		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal	V 536		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF ANGELS	2187 LAUREN MILL DRIVE OXFORD, NC 27565

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compliance and demonstrate they acted on data gathered.
(d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(e) Formal refresher training must be completed by each service provider periodically (minimum annually).
(f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.
(g) Staff shall demonstrate competence in the following core areas:
(1) knowledge and understanding of the people being served;
(2) recognizing and interpreting human behavior;
(3) recognizing the effect of internal and external stressors that may affect people with disabilities;
(4) strategies for building positive relationships with persons with disabilities;
(5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;
(6) recognizing the importance of and assisting in the person's involvement in making decisions about their life;
(7) skills in assessing individual risk for escalating behavior;
(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and
(9) positive behavioral supports (providing means for people with disabilities to choose

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V 536	Continued From page 14 activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures.	V 536		

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V 536	Continued From page 15 (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by:	V 536		

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Based on record review and interview the facility failed to ensure one of one staff (#2) demonstrated competency in the use of Alternatives to Restrictive Interventions. The findings are:

Review on 2/4/22 of staff #2's record revealed
-Alternative to Family Living (AFL) provider
-Hire date of 5/1/1
-Training in Alternatives to Restrictive Interventions dated 7/8/21

Review on 2/4/22 of Former Client (FC) #1's record revealed:
-Admission date of 3/15/21
-Diagnoses of Moderate Intellecutual Developmentally Disability (IDD), Schizoaffective Disorder-Bipolar Type, Mild Depressed Bipolar Disorder and Mixed Hyperlipidemia.

Refer to V110 for information regarding the incident report dated 1/19/22 for FC #1.

Interview on 2/1/22 staff #2 stated:
-On 1/19/22 after arriving at the restaurant to pick up food, FC #1 was beating on the car windows.
-When she opened the door, FC #1 swung at her then he jumped out of the car and ran inside the restaurant.
-FC #1 ran into the restaurant behind the counter and hit a man in the head that worked in the restaurant.
-FC #1 then tried to go into the kitchen.
-The man who worked in the restaurant then physically blocked FC #1 from getting into the kitchen.
-Several minutes went by where FC #1 was threatening and attempting to hit the male restaurant worker.
-The male restaurant worker was trying to get him

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V 536	Continued From page 17 to calm down. -Did not attempt to calm FC #1 down because he was not listening to her. -She called the police and FC #1 began to calm down -She then was able to get FC #1 to leave with her and they returned home. -A female who worked in the restaurant had videoed the incident for "liability purposes" and sent the video to her. Review on 2/1/22 at 10:30 AM of a video of FC #1 in the restaurant revealed: -FC #1 was standing in front of the kitchen door with his fist drawn back toward the male restaurant worker saying "I'm gonna hit you." -The male restaurant worker was standing in front of him telling him to calm down and that no one was going to hit him. -FC #1 did grab at the male restaurant hands and held them while continuing to draw his fist back. -The video went on for several minutes. -There was no intervening during the video of staff #2 physically or verbally. -Police arrived on the scene and were observed talking to staff #2 while the male restaurant worker was still trying to calm FC #1. Interview on 2/7/22 the male restaurant worker stated: -Was sitting by the window while on his break when FC #1 came running into the restaurant. -Saw FC #1 heading toward the kitchen and jumped to block him. -Was familiar with FC #1 as he had been in the restaurant many times with staff #2. -Had never seen FC #1 this upset. -FC #1 was crying and yelling, "she hit me, she hit me." -FC #1 was also saying "don't let the police get	V 536		

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me."
-FC #1 never hit him, only gave him the "finger."
-Was trying to calm FC #1 by letting him know he was safe.
-Staff #2 was on the other side of the counter and not engaging with FC #1.
-Staff #2 was obviously the one FC #1 was upset with.
-Staff #2 told him FC #1 had been asking to call the police, "but the way he was acting, there was no way he wanted to call the police because that made him more upset."
-"I was the only one that calmed him down."
-"No one tried to calm him (FC #1) down but me."
-"I have never seen fear in a person's face like that."
-"[FC #1] was literally trying to get away from [staff #2]."
-After the police arrived, he stood back and let them handle the situation.
-FC #1 then calmed down and hugged him.
-Helped walk FC #1 out to the car and he left with staff #2.
-"Very concerned" about FC #1's safety as staff #2 did not even try to calm him and protect him.

Interview on 2/10/22 a female restaurant worker stated:
-Was working on 1/19/22 when FC #1 came running into the restaurant "hard as he could"
-Was familiar with FC #1 as he had been in several times with staff #2 to eat.
-FC #1 went behind the counter and was heading toward the kitchen door when her male co-worker stopped him.
-FC #1 was crying saying "she hit me, she hit me."
-Never saw staff #2 try to calm FC #1 down.
-Staff #2 stood behind the counter the entire time and "did not say one word."

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-Her male co-worker was the only one getting FC #1 to calm down.
-When the police arrived, "she (staff #2) didn't even deal with the police" to help him.
-"It was like she (staff #2) was not even there, she did not do a d**n thing."
-Finally FC #1 calmed down and left with staff #2.
-She and the other staff were all "traumatized" after this event and "felt so sorry" for FC #1.
-The restaurant was full of customers and they were all sympathetic to this client and upset with how staff #2 handled the situation.

Interview on 2/4/22 the agency trainer in Alternatives to Restrictive Interventions stated:
-She had trained staff #2 in Alternatives to Restrictive Interventions.
-As an agency, they have a no holds policy unless absolute necessary.
-Staff #2 should have been actively engaging with FC #1 to help deescalate the situation.

Interview on 2/9/22 the clinical director stated:
-Staff #2 had told her about the incident on 1/19/22.
-Staff #2 told her she pulled over on an exit because FC #1 was beating on the glass.
-Once she pulled over, FC #1 unbuckled his seatbelt and ran into the restaurant where he ran behind the counter and struck a male restaurant employee in the head.
-Staff #2 told her she called 911 at that point due to FC #1's aggressive behaviors.
-Was not aware of any other story of what happened in the restaurant until she viewed the video this week.
-After viewing the video, staff #2 should have been trying to calm FC #1 down instead of a person who was not trained or familiar with him.
-"Very upset" to learn that staff #2 had not done

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V 536	Continued From page 20 anything to help deescalate FC #1 in the restaurant. -Understood that staff #2 only called the police because he had assaulted someone and she could not get him to calm down. This deficiency is cross referenced into 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110) for a Type A1 rule violation and must be corrected within 23 days.	V 536		