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| V 000 | INITIAL COMMENTS<br><br>An annual and complaint survey was completed on March 2, 2022. Two complaints were substantiated (Intake #NC00182857 and #NC00185986) and one complaint was unsubstantiated (Intake #NC00182385). Deficiencies were cited.<br><br>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.<br><br>This facility is licensed for 4 and currently has a census of 4. The survey sample consisted of audits of 5 current clients (one client was discharged, and another admitted during the survey) and 3 former clients.<br><br>Two sister facilities are identified in this report. The sister facilities will be identified as Sister Facility A and Sister Facility B. Staff will be identified using the letter of the facility and a numerical identifier.<br><br>A summary suspension was issued on March 2, 2022. | V 000 | | |
| V 107 | 27G .0202 (A-E) Personnel Requirements<br><br>10A NCAC 27G .0202 PERSONNEL REQUIREMENTS<br>(a) All facilities shall have a written job description for the director and each staff position which:<br>(1) specifies the minimum level of education, competency, work experience and other qualifications for the position;<br>(2) specifies the duties and responsibilities of the position; | V 107 | | |

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| V 107 | Continued From page 1<br>(3) is signed by the staff member and the supervisor; and<br>(4) is retained in the staff member's file.<br>(b) All facilities shall ensure that the director, each staff member or any other person who provides care or services to clients on behalf of the facility:<br>(1) is at least 18 years of age;<br>(2) is able to read, write, understand and follow directions;<br>(3) meets the minimum level of education, competency, work experience, skills and other qualifications for the position; and<br>(4) has no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry.<br>(c) All facilities or services shall require that all applicants for employment disclose any criminal conviction. The impact of this information on a decision regarding employment shall be based upon the offense in relationship to the job for which the applicant is applying.<br>(d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided.<br>(e) A file shall be maintained for each individual employed indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification. | V 107 | | |

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| V 107 | Continued From page 2<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure a written job description was present in each staff member's file affecting 3 of 11 audited current staff (Staff #2, #4, and #5) and 3 of 4 audited former staff (Former Staff #8, #9, and #10) and failed to ensure each staff member met the minimum education requirements for their position affecting 5 of 11 audited current staff (Staff #3, #4, #5, #6, and #7) and 1 of 4 audited former staff (Former Staff #11). The findings are:<br><br>Refer to V108 for employment dates and job titles.<br><br>Review on 2/23/22 of Staff #2's record revealed:<br>-No job description available for review.<br><br>Review on 12/28/21 and 2/24/22 of Staff #3's record revealed:<br>-No education credentials for position of the Associate Professional (AP) available for review.<br><br>Review on 2/24/22 of Staff #4's record revealed:<br>-No job description or education credentials available for review.<br><br>Review on 2/24/22 of Staff #5's record revealed:<br>-No job description or education credentials available for review.<br><br>Review on 2/23/22 and 2/24/22 of Staff #6's record revealed:<br>-No education credentials available for review.<br><br>Review on 2/24/22 of Staff #7's record revealed:<br>-No education credentials available for review. | V 107 | | |

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| V 107 | Continued From page 3<br><br>Review on 12/20/21 and 12/21/21 of Former Staff #8's record revealed:<br>-No job description available for review.<br><br>Review on 12/28/21 and 2/24/22 of Former Staff #9's record revealed:<br>-No job description available for review.<br><br>Review on 12/28/21 and 2/24/21 of Former Staff #10's record revealed:<br>-No job description available for review.<br><br>Review on 12/28/21 and 2/24/22 of Former Staff #11's record revealed:<br>-No educational credentials available for review.<br><br>Interview on 2/25/22 with Staff #3 revealed:<br>-Denied working at the facility;<br>-Acknowledged working at Sister Facility A;<br>-Denied accepting the position of AP on or about 2/7/22.<br><br>Interviews on 2/24/22 and 3/2/22 with the Licensee-Qualified Professional #2 (L-QP#2) revealed:<br>-Several staff separated from employment during the Division of Health Service Regulation (DHSR) survey: Staff #4 on 1/25/22, Staff #5 on 1/7/22, Staff #6 on 2/21/22, and Staff #7 on 1/16/22;<br>-Staff #3 recently accepted the position of AP signing the job description on 2/7/22. She graduated from a local state university but did not have access to her degree or transcript to provide evidence of the education credentials. She was working to obtain the necessary documentation;<br>-Did not know why Staff #3 denied working at the facility or accepting the position of AP;<br>-Acknowledged some job descriptions and education credentials were missing for staff but could not identify the reason; | V 107 | | |

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| V 107 | Continued From page 4<br>-Would ensure all job descriptions and education credentials be obtained as soon as possible;<br>-When asked if there was additional information to present or comments to make during the survey exit meeting on 3/2/22, no additional information was provided by L-QP #2.<br><br>This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation. | V 107 | | |
| V 108 | 27G .0202 (F-I) Personnel Requirements<br><br>10A NCAC 27G .0202 PERSONNEL REQUIREMENTS<br>(f) Continuing education shall be documented.<br>(g) Employee training programs shall be provided and, at a minimum, shall consist of the following:<br>(1) general organizational orientation;<br>(2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B;<br>(3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and<br>(4) training in infectious diseases and bloodborne pathogens.<br>(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. | V 108 | | |

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| V 108 | Continued From page 5<br>(i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, the facility failed to provide required training affecting 11 of 11 audited current staff (Staff #1, #2, #3, #4, #5, #6, #7, Associate Professional, Qualified Professional #1, Licensed Professional, and Licensee-Qualified Professional #2) and 4 of 4 audited former staff (Former Staff #8, #9, #10, and #11). The findings are:<br><br>Review on 12/2/21 and 2/24/22 of Client #2's record revealed:<br>-Admitted 7/26/21;<br>-Diagnosed with Post-Traumatic Stress Disorder, Oppositional Defiant Disorder, Mood Disorder, Major Depressive Disorder, and Insomnia;<br>-17 years old;<br>-Treatment plan dated 10/28/21 updated 12/27/21 revealed Client #2 exchanged sexualized writings with a peer (with no identification of the peer).<br><br>Review on 12/17/21 of Staff #1's record revealed:<br>-Hired 7/30/20;<br>-Employed as Residential Assistant;<br>-No training in sexually aggressive youth.<br><br>Review on 2/23/22 of Staff #2's record revealed:<br>-Hired 2/14/22;<br>-Employed as Residential Assistant; | V 108 | | |

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| V 108 | Continued From page 6<br>-No training in sexually aggressive youth, general organizational orientation, client rights and confidentiality, meeting the needs of the clients as specified in the treatment plans, infectious diseases and bloodborne pathogens, first aid including seizure management, cardiopulmonary resuscitation and the Heimlich maneuver.<br><br>Review on 12/28/21 and 2/24/22 of Staff #3's record revealed:<br>-Hired 8/30/20;<br>-Employed as Residential Assistant;<br>-Signed job description dated 2/7/22 for Associate Professional (AP);<br>-No training in sexually aggressive youth.<br><br>Review on 2/24/22 of Staff #4's record revealed:<br>-Hired 12/24/21;<br>-Employed as Residential Assistant;<br>-No training in sexually aggressive youth, general organizational orientation, client rights and confidentiality, meeting the needs of the clients as specified in the treatment plans, infectious diseases and bloodborne pathogens.<br><br>Review on 2/24/22 of Staff #5's record revealed:<br>-Hired 10/9/21;<br>-Employed as Residential Assistant;<br>-No training in sexually aggressive youth.<br><br>Review on 2/23/22 and 2/24/22 of Staff #6's record revealed:<br>-Hired 12/21/21;<br>-Employed as Residential Assistant;<br>-No training in sexually aggressive youth, general organizational orientation, client rights and confidentiality, meeting the needs of the clients as specified in the treatment plans, infectious diseases and bloodborne pathogens. | V 108 | | |

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| V 108 | Continued From page 7<br><br>Review on 2/24/22 of Staff #7's record revealed:<br>-Hired 8/4/21;<br>-Employed as Residential Assistant;<br>-No training in sexually aggressive youth.<br><br>Review on 12/20/21 and 12/21/21 of Former Staff #8's record revealed:<br>-Hired 8/26/21;<br>-Separated from employment 12/11/21;<br>-Employed as Residential Assistant;<br>-No training in sexually aggressive youth.<br><br>Review on 12/28/21 and 2/24/22 of Former Staff #9's record revealed:<br>-Hired 7/1/21;<br>-Separated from employment 9/17/21;<br>-Employed as Residential Assistant;<br>-No training in sexually aggressive youth.<br><br>Review on 12/28/21 and 2/24/21 of Former Staff #10's record revealed:<br>-Hired 12/16/20;<br>-Rehired 6/30/21;<br>-Separated from employment 9/20/21;<br>-Employed as Residential Assistant.<br>-No training in sexually aggressive youth.<br><br>Review on 12/28/21 and 2/24/22 of Former Staff #11's record revealed:<br>-Hired 2/1/20;<br>-Rehired 9/29/21;<br>-Separated from employment 12/18/21;<br>-Employed as Residential Assistant;<br>-No training in sexually aggressive youth.<br><br>Review on 12/28/21 of the Associate Professional's record revealed:<br>-Hired 2/7/19;<br>-No training in sexually aggressive youth. | V 108 | | |

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Review on 2/14/22 of Qualified Professional #1's record revealed:
-Hired 2/5/19;
-No training in sexually aggressive youth.

Review on 2/14/22 of Licensed Professional record revealed:
-Hired 10/1/20;
-No training in sexually aggressive youth.

Review on 2/14/22 of Licensee-Qualified Professional #2's (L-QP#2) record revealed:
-Hired 2/5/19;
-No training in sexually aggressive youth.

Interview on 2/23/22 with Staff #2 revealed:
-Worked alone at times.

Interview on 2/25/22 with Staff #3 revealed:
-Denied working at the facility;
-Acknowledged working at Sister Facility A;
-Denied accepting the position of AP on or about 2/7/22.

Interviews on 2/15/22, 2/24/22, and 3/2/22 with the L-QP#2 revealed:
-Several staff separated from employment during the Division of Health Service Regulation (DHSR) survey: Staff #4 on 1/25/22, Staff #5 on 1/7/22, Staff #6 on 2/21/22, and Staff #7 on 1/16/22, and the AP on 2/4/22;
-Staff #1 was promoted to House Manager on 2/22/22;
-Staff #3 recently accepted the position of AP signing the job description on 2/7/22;
-Did not know why Staff #3 denied working at the facility or accepting the position of AP;
-Staff #2 was previously employed by another provider. Staff #2's training records were requested from the other provider, but no

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| V 108 | Continued From page 9<br>documents were received;<br>-Acknowledged Staff #4 and #6 were not trained in general organizational orientation, client rights and confidentiality, meeting the needs of the clients as specified in the treatment plans, infectious diseases and bloodborne pathogens;<br>-Had not provided any staff training regarding sexually aggressive youth despite the incidents of sexualized behaviors at the facility;<br>-Will secure staff training regarding sexually aggressive youth;<br>-When asked if there was additional information to present or comments to make during the survey exit meeting on 3/2/22, no additional information was provided by L-QP #2.<br><br>This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation. | V 108 | | |
| V 109 | 27G .0203 Privileging/Training Professionals<br><br>10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS<br>(a) There shall be no privileging requirements for qualified professionals or associate professionals.<br>(b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served.<br>(c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence.<br>(d) Competence shall be demonstrated by exhibiting core skills including:<br>(1) technical knowledge;<br>(2) cultural awareness;<br>(3) analytical skills; | V 109 | | |

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| V 109 | Continued From page 10<br>(4) decision-making;<br>(5) interpersonal skills;<br>(6) communication skills; and<br>(7) clinical skills.<br>(e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS.<br>(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.<br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, 3 of 3 qualified professionals (Qualified Professional #1, Licensed Professional, and Licensee-Qualified Professional #2) failed to demonstrate the knowledge, skills, and abilities required by the population served. The findings are:<br><br>Review on 2/14/22 of Qualified Professional #1's (QP#1) record revealed:<br>-Hired 2/5/19;<br>-Signed job description dated 8/14/19 revealed: "...provide and/or assure completion of required training for residential assistant employees ...develop task analyses and/or strategies for the implementation of goals ...complete all required | V 109 | | |

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training and staff development activities ...performing clinical and administrative responsibilities a minimum of 40 hours a week and 75% shall occur when the children or adolescents are awake and present in the facility, management of the day to day operation of the facility, supervision or paraprofessionals regarding responsibilities related to the implementation of each child or adolescents treatment plan ..."

Review on 2/14/22 of the Licensed Professional's (LP) record revealed:
-Hired 9/30/20;
-Signed job description dated 7/8/21 revealed: "...face to face clinical consultation shall be provided in each facility at least 4 hours a week ...must provide clinical supervision to the Qualified Professional monthly ...update treatment team on the progress of therapy with the clients ...involvement in the children or adolescents specific treatment plans and overall programming ..."

Review on 2/14/22 of Licensee-Qualified Professional #2's (L-QP#2) record revealed:
-Hired 2/5/19;
-Signed job description dated 1/27/19 revealed: "...provide and/or assure completion of required training for residential assistant employees, review and monitor service delivery schedules and employee attendance ...complete all required training and staff development activities ...report all incidents required in IRIS (North Carolina Incident Response Improvement System) ..."

Refer to V107 for failure to meet personnel requirements:
-Staff records missing job descriptions and required education credentials.

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| V 109 | Continued From page 12<br><br>Refer to V108 for failure to provide required staff training:<br>-No training in sexually aggressive youth despite Client #2 exchanging sexualized writings with a peer;<br>-No training in first aid and cardiopulmonary resuscitation for Staff #2;<br>-No training in general organizational orientation, client rights and confidentiality, meeting the needs of the clients as specified in the treatment plans, infectious diseases and bloodborne pathogens for Staff #2, #4, and #6.<br><br>Refer to V112 for failure to develop and implement treatment strategies:<br>-No treatment strategies developed to address Client #1's self-harm or AWOL (absent without leave);<br>-No treatment strategies developed to address Client #2's AWOL;<br>-No updated treatment strategies to address Client #3's assault despite assaulting Clients #2 and #4 resulting in Client #4 requiring medical evaluation;<br>-No treatment strategies developed to address Client #4's substance abuse prevention education, bullying, and assault;<br>-No treatment strategies developed to address Client #5's AWOL.<br><br>Refer to V131 for failure to complete Health Care Personnel Registry (HCPR) checks prior to an offer of employment:<br>-HCPR check completed after hire for Staff #4, #5, and #6.<br><br>Refer to V133 for failure to request criminal background checks within 5 days of an offer of employment: | V 109 | | |

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| V 109 | Continued From page 13<br>-Missing or late criminal background checks for Staff #4, #5, #6, #7, Former Staff #8, #10, #11, and the Associate Professional.<br><br>Refer to V294 for failure to provide required qualified professional services:<br>-QP#1 did not provide services at the facility a minimum of 10 hours weekly with at least 70% of the time when clients were awake and present;<br>-QP#1 did not develop treatment strategies to address the needs of Clients #1, #2, #3, #4, and #5.<br><br>Refer to V295 for failure to provide required associate professional services:<br>-Could not determine if an associate professional was employed at the facility.<br><br>Refer to V296 for failure to provide minimum staffing ratios:<br>-Only one staff present with up to four clients at times.<br><br>Refer to V297 for failure to provide required licensed professional services:<br>-LP did not provide face to face consultation to the clients weekly;<br>-LP provided phone calls or virtual visits to the clients;<br>-LP did not provide clinical supervision around client care and services to the QP#1.<br><br>Refer to V336 for failure to implement the incident reporting policy and report Level I incidents:<br>-No incident report completed on Client #1's self-harming wounds discovered on 12/31/21;<br>-No incident reports completed on Client #2's verbal aggression, attack by a peer (Client #3), or exchange of sexualized writings;<br>-No incident report completed on Client #4's | V 109 | | |

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verbal aggression and bullying;
-No incident report completed on Former Client #6's (FC#6) social media use.

Refer to V367 for failure to complete Level II incident reports:
-No Level II incident reports for the calls to local law enforcement on 9/24/21 (twice), 9/26/21 (twice), 9/29/21, 9/30/21, 10/1/21, 11/22/21, and 1/4/22;
-No Level II incident reports when Clients #2, #4, and Former Client #6 each pierced their own noses.

Refer to V774 for failure to ensure minimum furnishings:
-A client's bedroom was furnished with only a bed and linens.

Interviews on 12/28/21 and 2/16/22 with the QP#1 revealed:
-Client #4 did not receive any substance abuse prevention education while at the facility due to her discharging after only 7 weeks at the facility;
-Acknowledged treatment plans did not have strategies to address the needs of clients served at the facility but could not provide any explanation;
-Completed virtual visits to the facility;
-Completed most of her work from the office that was not located at the facility but was located at an off-site office building;
-Worked when the clients were in school and only saw the clients virtually;
-Did not meet with the LP for clinical supervision.

Interview on 1/10/22 with the LP revealed:
-Provided LP services at the facility on Wednesdays arriving between 3-4pm weekly;
-Time spent at the facility varied depending upon

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which client(s) wanted to meet for therapy;
-Missed sessions for three weeks at the end of November, 2021 lasting into December, 2021 due to medical issues of surgery and illness related to the pandemic;
-Could not identify if there was any LP filling in during the time of illness replying "not to my knowledge;"
-All clinical notes were kept in a book in her possession;
-Upon request of clinical notes for the past three months, the LP revealed she could not provide them within the 6-hour window presented by Division of Health Service Regulation (DHSR) staff but would be able to provide them within 24 hours;
-Acknowledged providing telehealth appointments "a couple of times" due to the pandemic but revealed she did not document within the therapy note if the session was virtual or in person.

Additional attempted interviews with the LP were unsuccessful. A request was made by DHSR on 2/14/22 at 11:45am for the L-QP#2 to arrange a telephone interview between DHSR and the LP. Despite attempts to arrange a telephone interview, no telephone call was received from the LP. An additional attempt was made by DHSR on 2/16/22 at 9:50am via telephone call to the LP. The following message was on the LP's telephone: "The wireless customer you are calling is not available. Please try your call again later."

Interviews on 2/9/22, 2/10/22, 2/15/22, and 3/2/22 with the L-QP#2 revealed:
-Acknowledged some job descriptions and education credentials were missing for staff but could not identify the reason;
-Staff #2 was previously employed by another

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provider. Staff #2's training records were requested from the other provider, but no documents were received;
-Acknowledged Staff #4 and #6 were not trained in general organizational orientation, client rights and confidentiality, meeting the needs of the clients as specified in the treatment plans, infectious diseases and bloodborne pathogens;
-Had not provided any staff training regarding sexually aggressive youth despite the incidents of sexualized writings by Client #2 but was scheduling such training after Division of Health Service Regulation citations at Sister Facility B;
-Had not ensured Staff #4 and #6 were trained in general organizational orientation, client rights and confidentiality, meeting the needs of the clients as specified in the treatment plans, infectious diseases and bloodborne pathogens;
-Did not know the specifics about Former Staff #8 (FS#8) falling asleep while on duty with clients present as she did not handle the situation;
-Not sure why the HCPR reviews were completed after the hire dates for Staff #4, #5, and #6;
-Was not able to identify initial dates of separation for Former Staff #10 and #11;
-Acknowledged criminal background checks were requested late for several staff but could not identify the reason;
-Not sure why there was missing criminal background checks on several staff members;
-Was aware the QP#1 needed to be present in the facility for 10 hours weekly with 70% of the time being when the clients were present and awake;
-Was not aware the QP#1 was not present in the facility when the clients were present;
-When asked if there was additional information to present or comments to make during the survey exit meeting on 3/2/22, the L-QP #2 revealed the QP#1 was not in the facility due to

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| V 109 | Continued From page 17<br>illness related to the pandemic which lasted one to two weeks and the LP was not in the facility due to illness related to the pandemic but did not identify a time frame.<br>-Tried to schedule two staff to work each shift but sometimes had difficulty with staffing ratios due to staff calling out resulting in only one staff at times;<br>-Was not aware the LP was not present at the facility to conduct therapy with the clients;<br>-Was not sure why all incident reports were not completed;<br>-Was aware of the number of calls seeking law enforcement assistance for FC#7 due to continued AWOLS but "there was nothing we could do to stop the AWOLs;"<br>-Clients #2, #4, and FC#6 did not receive any medical attention after the discovery of the self-piercings;<br>-Clients #1 and #4 did not receive any medical attention after the discovery of the self-harming wounds on 12/31/21 and on or about 1/3/22, respectively;<br>-Did not secure any mental health evaluation for Client #1 on 12/31/21 when she displayed suicidal ideation as she refused medical attention upon arrival of Emergency Medical Services to the facility;<br>-No medical records were available for review from the 12/31/21 hospital assessment completed on Client #4 after she displayed suicidal ideation;<br>-Had ordered and received additional furnishings for the bedroom but needed to assemble the items;<br>-FC#6 went AWOL and never returned to the facility and was discharged;<br>-FC#8 went AWOL and never returned to the facility and was discharged;<br>-Client #3 was discharged on 2/11/22 on her 18th birthday and returned home to her mother; | V 109 | | |

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| V 109 | Continued From page 18<br>-Client #4 was discharged on 1/20/22.<br><br>Despite multiple attempts throughout the survey, it could not be determined if all current and former staff were identified by the L-QP#2. Through interviews and record reviews, it was discovered that two staff who were employed at the start of the survey were not identified by the L-QP#2 upon request to identify all current staff. Furthermore, three former staff were not identified by the L-QP#2 until the review of the audio recordings to law enforcement/emergency services provided by the county's 911 Coordinator at which time the L-QP#2 acknowledged the employment of the former staff.<br><br>This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation. | V 109 | | |
| V 112 | 27G .0205 (C-D)<br>Assessment/Treatment/Habilitation Plan<br><br>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN<br>(c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days.<br>(d) The plan shall include:<br>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;<br>(2) strategies;<br>(3) staff responsible;<br>(4) a schedule for review of the plan at least annually in consultation with the client or legally | V 112 | | |

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| V 112 | Continued From page 19<br>responsible person or both;<br>(5) basis for evaluation or assessment of outcome achievement; and<br>(6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, the facility failed to develop and implement treatment strategies to meet the needs of the clients affecting 5 of 5 current clients (Clients #1, #2, #3, #4, and #5) and 1 of 3 former clients (Former Client #7). The findings are:<br><br>Review on 12/2/21 and 2/24/22 of Client #1's record revealed:<br>-Admitted 8/18/21;<br>-Diagnosed with Post-Traumatic Stress Disorder, Generalized Anxiety Disorder, Major Depressive Disorder, Disruptive Mood Dysregulation Disorder, Child Sexual Abuse - Victim, Child Neglect, and Cannabis Use Disorder;<br>-15 years old;<br>-Assessment dated 10/7/21 completed by Qualified Professional #1 (QP#1) revealed a history of self-harm by cutting herself on her arms and legs with sharp objects, overdosing twice on pills, going AWOL (absent without leave) for up to two weeks traveling to a different county;<br>-Treatment plan updates on 11/18/21 and 1/12/22 | V 112 | | |

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revealed that while at the facility she pierced her own nose with a foreign object, was found to have healing self-harming wounds, had gone AWOL and displayed suicidal ideation;
-Treatment plan dated 1/12/22 did not include strategies to address self-harm or AWOL.

Review on 12/2/21 and 2/24/22 of Client #2's record revealed
-Admitted 7/26/21;
-Diagnosed with Post-Traumatic Stress Disorder, Oppositional Defiant Disorder, Mood Disorder, Major Depressive Disorder, and Insomnia;
-17 years old;
-Assessment dated 7/18/21 completed by QP#1 revealed a history of AWOL;
-Treatment plan update on 12/27/21 revealed that while at the facility she had gone AWOL for several days and had unprotected sex with an unidentified male;
-Treatment plan dated 10/28/21 with updates on 12/27/21 and 1/21/22 did not include strategies for AWOL or sexualized behaviors.

Review on 12/2/21 and 2/14/22 of Client #3's record revealed:
-Admitted 10/8/21;
-Diagnosed with Post-Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, and Disruptive Mood Dysregulation Disorder;
-17 years old;
-Assessment dated 10/7/21 completed by QP#1 revealed a history of verbal and physical aggression with peers including hitting a peer's head into cement, self-harm behaviors of scratching herself and overdosing on pills, and AWOL for up to one month with a peer;
-Treatment plan dated 11/22/21 was not revised to include new treatment strategies after Client #3 assaulted Client #2 on 11/22/21 or after Client #3

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assaulted Client #4 on 1/4/22 sending Client #4 to the hospital for medical evaluation. Furthermore, the treatment plan did not include strategies for AWOL.

Review on 12/29/21 and 2/14/22 of Client #4's record revealed:
-Admitted 12/3/21;
-Diagnosed with Post-Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, Generalized Anxiety Disorder, and Bipolar Disorder;
-14 years old;
-Undated assessment completed by QP#1 revealed history of criminal behaviors of assault, and history of truancy due to substance abuse;
-Treatment plan dated 12/28/21 revealed history of verbal aggression as evidenced of bullying, and Client #4 was scheduled to start substance abuse education (no start date was indicated in the treatment plan);
-Treatment plan dated 12/28/21 did not include strategies to address bullying, assault, or substance abuse prevention.

Review on 2/22/22 and 2/23/22 of Client #5's record revealed:
-Admitted 1/24/22;
-Diagnosed with Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, and Bipolar Disorder;
-16 years old;
-Assessment dated 1/26/22 completed by QP#1 revealed a history of over 20 AWOLs prior to placement at the facility;
-Treatment plan dated 1/11/22 did not include strategies for AWOL.

Review on 12/2/21 and 12/28/21 of Former Client #7's (FC#7) record revealed:

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| V 112 | Continued From page 22<br>-Admitted 7/28/21;<br>-Discharged 10/7/21<br>-Diagnosed with Diagnoses Post-Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder, and Gender Identity Disorder in Adolescents or Youth;<br>-17 years old;<br>-Treatment Plan dated 8/25/21 did not include updated strategies for AWOL despite FC#7's 6 AWOL episodes in one week requiring law enforcement intervention.<br><br>Interviews on 12/28/21 and 2/16/22 with the QP#1 revealed:<br>-Client #4 did not receive any substance abuse prevention education while at the facility due to her discharging after only 7 weeks at the facility;<br>-Acknowledged treatment plans did not have strategies to address the needs of clients served at the facility but could not provide any explanation;<br>-Completed virtual visits to the facility;<br>-Completed most of her work from the office that was not located at the facility but was located at an off-site office building;<br>-Worked when the clients were in school and only saw the clients virtually;<br>-Did not meet with the Licensed Professional (LP) for clinical supervision around client care and services.<br><br>Interviews on 2/10/22, 2/15/22, and 3/2/22 with the Licensee-Qualified Professional #2 (L-QP#2) revealed:<br>-Client #3 was discharged on 2/11/22 on her 18th birthday and returned home to her mother;<br>-Client #4 was discharged on 1/20/22;<br>-Was aware of the number of calls seeking law enforcement assistance for FC#7 due to continued AWOLS but "there was nothing we | V 112 | | |

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| V 112 | Continued From page 23<br>could do to stop the AWOLs;"<br>-Will instruct the QP#1 to develop treatment plan strategies to address the needs of the clients.<br><br>This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation. | V 112 | | |
| V 118 | 27G .0209 (C) Medication Requirements<br><br>10A NCAC 27G .0209 MEDICATION REQUIREMENTS<br>(c) Medication administration:<br>(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.<br>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.<br>(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.<br>(4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following:<br>(A) client's name;<br>(B) name, strength, and quantity of the drug;<br>(C) instructions for administering the drug;<br>(D) date and time the drug is administered; and<br>(E) name or initials of person administering the drug.<br>(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation | V 118 | | |

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| V 118 | Continued From page 24<br>with a physician.<br><br>This Rule is not met as evidenced by:<br>Based on interview, record review, and observation, the facility failed to ensure medications were administered by persons properly trained by a qualified person, prescription and non-prescription drugs were administered to clients upon the written order of a person authorized by law to prescribe medications, and MARs listing all medications administered were kept current affecting 5 of 5 current clients (Clients #1, #2, #3, #4 and #5) and 1 of 3 former clients (Former Client #6). The findings are:<br><br>CROSS REFERENCE: 10A NCAC 27G .0209 (V120)<br>Based upon interview, record review, and observation, the facility failed to ensure medications were stored securely affecting 3 of 5 current clients (Client #1, #2, and #4) and 1 of 3 former clients (Former Client #6) and stored separately for external and internal use affecting 2 of 5 current clients (Clients #2 and #3).<br><br>CROSS REFERENCE: 10A NCAC 27G .0209 (V123)<br>Based upon interview and record review, the facility failed to ensure medication errors were reported to a physician or pharmacist and properly recorded affecting 3 of 5 clients (Clients #1, #2, and #4). | V 118 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| V 118 | Continued From page 25<br><br>Review on 2/22/22 and 2/23/22 of Client #5's record revealed:<br>-Admitted 1/24/22;<br>-Diagnosed with Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, and Bipolar Disorder;<br>-16 years old.<br><br>Finding #1<br>Review on 2/23/22 of Staff #2's record revealed:<br>-Hired 2/14/22;<br>-Employed as Residential Assistant;<br>-No medication administration training;<br>-Certificate for online training from neighboring local management entity identified training in "Medical Record Administration Training."<br><br>Review on 2/24/22 of Staff #5's record revealed:<br>-Hired 10/9/21;<br>-Employed as Residential Assistant;<br>-No medication administration training.<br><br>Review on 2/24/22 and 2/25/22 of Clients #1, #2 and #5's February, 2022 MARs revealed:<br>-Medications administered by Staff #2.<br><br>Attempted review of all shifts worked by Staff #5 with corresponding MARs for those shifts and interview with the Licensee-Qualified Professional #2 (L-QP#2) was unsuccessful. The documents were requested from the L-QP#2 via telephone at 8:46am. L-QP#2 revealed she could not provide the information as she was not in the office due to a headache but would send the documentation via secured email later in the day. No documentation was received.<br><br>Review on 2/24/22 of Staff #A1's record revealed:<br>-Employed as a Residential Assistant (at Sister Facility A); | V 118 | | |

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| V 118 | Continued From page 26<br>-Highest level of education was a GED (General Educational Development) Certificate.<br><br>Interview on 2/23/22 with Staff #2 revealed:<br>-Administered medications at the facility;<br>-Received one-on-one training with Staff #A1 for medication administration training;<br>-Did not know Staff #A1's position at Sister Facility A or Staff #A1's level of education.<br><br>Interview on 2/22/22 with Staff #5 revealed:<br>-Administered medications at the facility;<br>-Did not receive any medication administration training;<br>-Supervisors at the facility "turned a blind eye" and "did not get services for the clients;"<br>-Supervisors "acted like the direct care workers were the problem;"<br>-"Working there (Trinity House) was such a bad experience ...it was terrible."<br><br>Attempted interview on 2/25/22 with Staff #A1 was unsuccessful. A recorded message revealed "subscriber was not available."<br><br>Interview on 2/24/22 with Training and Special Projects Manager for the neighboring local management entity offering "Medical Record Administration Training" revealed:<br>-The training course was an "online pre-recorded course developed by the medical team." It was "not designed to meet the requirements of a medication administration course." It was a "supplemental course to assist with how to record medication administration and complete accurate records." It did not meet the requirements set forth in 10A NCAC 27G .0209 Medication Requirements for medication administration training. | V 118 | | |

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| V 118 | Continued From page 27<br><br>Finding #2<br>Review on 12/1/21, 12/28/21, and 2/21/22 of Client #1's medication orders revealed:<br>-Aripiprazole (depression) 5mg (milligrams) 1 cap (caplet) daily dated 11/16/21, but no previous order available for review;<br>-Cetirizine (allergies)10mg 1 cap daily dated 11/16/21, but no previous order or discontinue order available for review;<br>-Flonase Allergy Relief (allergies) 50mcg (micrograms) 1 spray to both nostrils dated 11/16/21;<br>-Buspirone (anxiety) 10mg 1 tab (tablet) twice daily dated 12/21/21;<br>-No start order for Sertraline HCL (anxiety) 100mg 1 tab daily, but discontinue order dated 12/21/21;<br>-No start order for Vitamin D3 (supplement) 5,000 units 1 tab daily, but discontinue order dated 12/21/21;<br>-No start order for Vistaril 25mg (anxiety) 1 tab three times daily as needed, but discontinue order dated 12/21/21.<br><br>Review on 12/1/21 and 2/21/22 of Client #1's October, 2021 through February, 2022 MARs listed the following medications with initials indicating medication administration revealed:<br>-Aripiprazole 5mg 1 cap daily on the October through February MARs;<br>-Cetirizine 10mg 1 cap daily on the October through December MARs;<br>-Cetirizine was not listed on the January and February MARs;<br>-Flonase Allergy Relief 50mcg 1 spray to both nostrils was not listed on the November and December MARs;<br>-Flonase Propionate 50mcg 2 sprays to both nostrils was listed on the January and February MARs despite there being no order; | V 118 | | |

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| V 118 | Continued From page 28<br><br>-Buspirone 10mg listed on the January and February MARs, but not on the December MAR despite the order dated 12/21/21;<br>-Sertraline HCL 100mg 1 tab daily, Vitamin D3 5,000 units 1 tab daily, and Vistaril 25mg 1 tab three times daily as needed were listed on the October and November MARs despite there being no order prior to 11/16/21.<br><br>Observation on 12/1/21 at approximately 3:50pm and 2/21/22 at approximately 10:50am of Client #1's medication revealed:<br>-No Flonase Allergy Relief 50mcg present on 12/1/21, but it was present on 2/21/22;<br>-No Sertraline HCL 100mg, Vitamin D3 5,000units, and Vistaril 25mg present on both 12/1/21 and 2/21/22;<br>-Buspirone 10mg present on 2/21/22 with a dispense date of 2/16/22;<br>-Fluticasone Propionate 50mcg present on 2/21/22 with a dispense date of 2/21/22.<br><br>Review on 12/1/21 and 2/21/22 of Client #2's medication orders revealed:<br>-No orders for:<br>-Benzoyl Peroxide (acne) 5% wash face twice daily;<br>-Prilosec (stomach) 20mg 1 tab daily;<br>-Vitamin D 1000 units 1 tab daily;<br>-Clindamycin Phosphate (acne) 1% to affected area twice daily;<br>-No signed orders available upon initial request on 12/1/21 but later presented dated 12/21/21 for:<br>-Zyrtec (allergies) 10mg 1 tab daily;<br>-Fluoxetine HCL (depression) 40mg 1 cap daily;<br>-Trazodone (sleep) 50mg 1 tab daily;<br>-Emoquette (birth control) 28-day 1 tab daily.<br><br>Review on 12/1/21 and 2/21/22 of Client #2's October-December, 2021 and February, 2022 | V 118 | | |

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| V 118 | Continued From page 29<br><br>MARs listed the following medications with initials indicating medication administration revealed:<br>-Zyrtec 10mg missing 8 signatures in October;<br>-Prilosec 20mg missing 8 signatures in October;<br>-Vitamin D 1000 units missing 4 signatures in October;<br>-Benzoyl Peroxide 1% missing 2 signatures October and 5 signatures in February;<br>-Clindamycin Phosphate 1% missing 1 signature in February.<br><br>Observation on 12/1/21 at approximately 3:40pm and 2/21/22 at approximately 10:35am of Client #2's medications revealed:<br>-Zyrtec 10mg dispensed 10/8/21 and 1/3/22;<br>-Benzoyl Peroxide 5% dispensed 10/8/21and 1/19/22;<br>-Prilosec 20mg dispensed 10/8/21 and 1/3/22;<br>-Vitamin D 1000 units dispensed 10/8/21 and 1/3/22;<br>-Clindamycin Phosphate 1% dispensed 10/8/21 and 2/10/22;<br>-Fluoxetine HCL 40mg dispensed 10/19/21 and 2/9/22;<br>-Trazodone 50mg dispensed 11/26/21 and 1/24/22;<br>-Emoquette 28day dispensed 11/1/21 and 1/19/22.<br><br>Attempted review on 2/21/22 and 2/25/22 of Client #2's January, 2022 MAR was unsuccessful. The MAR was not at the facility on 2/21/22. Request on 2/25/22 to the L-QP#2 was also unsuccessful as the L-QP#2 revealed she was not in the office due to a headache but would send the documentation via secured email later in the day. No documentation was received.<br><br>Attempted review on 12/1/21 of Client #3's medication orders was unsuccessful as there | V 118 | | |

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| V 118 | Continued From page 30<br>were no signed orders available for review.<br><br>Review on 12/28/21 of Client #3's signed medication orders dated 12/21/21 revealed:<br>-Abilify (depression) 10mg 2 tabs at bedtime;<br>-Clindamycin ER (extended release) 2% vaginal cream extended release to skin daily;<br>-Fish Oil (supplement) 1200mg caps 1 daily;<br>-Fluticasone Propionate (allergies) 0.005% topical ointment to affected area daily;<br>-Gabapentin (mood) 300mg 2 caps daily;<br>-Guanfacine ER (attention) 4mg 1 tab daily;<br>-Hydroxyzine HCl (anxiety) 25mg 1 tab as needed every 6 hours;<br>-Melatonin (sleep) 10mg 1 tab at bedtime<br>-Metformin (diabetes) ER 500mg 1 tab twice daily;<br>-Microgestin Fe (birth control) 1.5/30 (28) 1 tab daily;<br>-Stool Softener 100mg 1 tab daily as needed<br>-Zoloft (mood) 50mg 1 tab daily;<br>-Zyrtec (allergies) 10mg 1 tab daily as needed;<br>-Magnesium (supplement) 30mg 1 tab daily for 7 days;<br>-Benztropine (side effects) 1mg 1 tab at bedtime was discontinued on 12/21/21;<br>-Gabapentin 300mg 1 cap three times daily was discontinued on 12/21/21;<br>-Hydroxyzine HCL 25mg 1 tab every 6 hours as needed was discontinued 12/21/21;<br>-Zoloft 25mg 1 tab every morning was discontinued 12/21/21;<br>-There were no other medication orders available.<br><br>Review on 12/1/21 of Client #3's October, November, and December, 2021 MARs listed the following medications with initials indicating medication administration revealed:<br>-Aripiprazole 20mg 1 tab daily;<br>-Clindamycin Phosphate 1% to area twice daily; | V 118 | | |

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| V 118 | Continued From page 31<br>-Fish Oil 1200 mg 1 cap twice daily;<br>-Flonase 50mcg 2 sprays per nostril;<br>-Gabapentin 300mg 1 cap daily;<br>-Guanfacine HCL ER 4mg 1 tab daily;<br>-Hydroxyzine HCL 25mg 1 tab every 6 hours as needed;<br>-Melatonin 10mg 1 tab daily;<br>-Metformin HCL 500mg 1 cap twice daily;<br>-Microgestin Fe 1 tab daily;<br>-Stool Softener 100mg 1 cap twice daily;<br>-Sertraline HCL 25mg 1 tab daily;<br>-Cetirizine HCL 10mg 1 tab daily;<br>-Magnesium 30mg 1 tab for 7 days (October, 2021);<br>-Benztropine 1 mg 1 tab at bedtime;<br>-Olopatadine HCL 2% 1 drop each eye.<br><br>Observation on 12/1/21 at approximately 3:20pm of Client #3's medications revealed:<br>-Aripiprazole 20mg was not in the facility;<br>-Clindamycin Phosphate 1%;<br>-Fish Oil 1200mg dispensed 11/23/21;<br>-Flonase 50mcg nasal spray;<br>-Gabapentin 300mg dispensed 11/26/21;<br>-Guanfacine HCL ER 4mg dispensed 10/19/21;<br>-Hydroxyzine HCL 25mg dispensed 11/23/21<br>-Melatonin 10mg dispensed 11/23/21;<br>-Metformin HCL 500mg dispensed 11/23/21;<br>-Microgestin Fe dispensed 10/19/21;<br>-Stool Softener 100mg dispensed 10/19/21;<br>-Sertraline HCL 25mg dispensed 11/26/21;<br>-Cetirizine HCL 10mg dispensed 11/23/21;<br>-Olopatadine HCL 2% dispensed 11/23/21.<br><br>Review on 2/21/22 of Client #4's medication orders revealed:<br>-No orders prior to those dated 12/21/21;<br>-Quetiapine (mood) 200mg 1 tab twice daily dated 12/21/21;<br>-Levonorgestrel 120mcg-Estradiol (birth control) | V 118 | | |

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| V 118 | Continued From page 32<br>30mcg 24-hour patch daily dated 12/21/21;<br>-Melatonin 10mg 1 tab at bedtime dated 12/21/21;<br>-Naltrexone (substance use) 50mg 1 tab daily dated 12/21/21, but no discontinue order;<br>-Banophen (sleep) 25mg 4 tabs at bedtime dated 12/21/21, but no discontinue order;<br>-Nicotine patch (smoking) 21 mg every morning dated 12/21/21;<br>-Prazosin (incontinence) 2mg 1 cap at bedtime discontinued 12/21/21;<br>-No order for Diphenhydramine (sleep) 25mg 2 caps at bedtime.<br><br>Review on 2/21/22 of Client #4's December, 2021 and January, 2022 MARs listed the following medications with initials indicating medication administration revealed:<br>-Quetiapine 200mg 1 tab twice daily missing 1 signature on the January MAR;<br>-Levonorgestrel 120mcg-Estradiol 30mcg 24-hour patch daily missing 1 signature on the January MAR;<br>-Melatonin 10mg 1 tab at bedtime was documented as administered on 12/1/21 and 12/2/21, but Client #4's admission date to the facility was 12/3/21;<br>-Naltrexone 50mg 1 tab daily noted as discontinued effective 1/8/22;<br>-Banophen 25mg 4 tabs at bedtime yellowed out with a notation of "DC" (discontinued) on the December MAR but was signed as administered through the end of the month;<br>-No documentation of the use of Nicotine Patch 21mg every morning.<br>-Prazosin 2mg 1 cap at bedtime yellowed out with a notation of "DC" on the December MAR but was signed as administered through the end of the month;<br>-Diphenhydramine 25mg 2 caps at bedtime | V 118 | | |

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| V 118 | Continued From page 33<br>started 12/21/21 and administered through January, 2022.<br><br>Observation on 2/21/22 at approximately 11:15am of Client #4's medication was not successful as Client #4 was discharged and none of Client #4's medication remained in the facility.<br><br>Attempted review on 2/21/22 of Client #5's medication orders was unsuccessful as there were no signed orders present at the facility. There was a computer printed note revealed the use of Vitamin D 2,000 units daily, Lithium Carbonate ER (mood) 600mg twice daily, and Culturelle (digestion) cap with no dosage or frequency.<br><br>Attempted review on 2/21/22 and 2/25/22 of Client #5's January, 2022 MAR and interview on 2/25/22 with L-QP#2 was unsuccessful. The MAR was not at the facility on 2/21/22. Request on 2/25/22 to the L-QP#2 was also unsuccessful as the L-QP#2 revealed she was not in the office due to a headache but would send the documentation via secured email later in the day. No documentation was received.<br><br>Review on 2/21/22 of Client #5's February, 2022 MAR listed the following medications with initials indicating medication administration revealed:<br>-Lactase 3,000 units 1 tab three times daily missing 11 signatures;<br>-Vitamin D 2,000 units 1 cap daily missing 2 signatures;<br>-Lithium Carbonate ER 300mg 2 tabs twice daily missing 9 signatures all of which were during the 7pm administration;<br>-Loratadine 10mg 1 tab daily missing 2 signatures;<br>-Fluticasone Prop. 50mcg 2 sprays per nostril | V 118 | | |

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| V 118 | Continued From page 34<br>missing 14 signatures;<br>-Aripiprazole 15mg 1 tab at hour of sleep missing 13 signatures;<br>-Culturelle cap 1 cap before meals three times daily was only listed on the MAR once for a 7pm administration and was missing 9 signatures for the 7pm administration and all signatures for administration twice daily each day of the month;<br>-Famotidine 20mg 1 tab daily missing 11 signatures.<br><br>Review on 2/24/22 of the facility secure application text message sent to all staff dated 2/21/22 revealed:<br>-"Reminder: [Client #5] has a paper MAR that needs to be signed ..."<br><br>Observation on 2/21/22 at approximately 11:05am of Client #5's medications revealed:<br>-Lactase 3,000 units dispensed 1/13/22;<br>-Vitamin D 2,000 dispensed 1/13/22;<br>-Lithium Carbonate ER 300mg dispensed 1/13/22;<br>-Loratadine 10mg;<br>-Fluticasone Propionate 50mcg dispensed 11/15/21;<br>-Aripiprazole 15mg, Culturelle cap, and Famotidine 20mg were not in the facility.<br><br>Interviews on 12/28/21, 12/29/21, 2/24/22, 2/25/22, and 3/2/22 with L-QP#2 revealed:<br>-Several staff separated from employment during the Division of Health Service Regulation (DHSR) survey: Staff #5 on 1/7/22;<br>-Staff #2 was previously employed by another provider. Staff #2's training records were requested from the other provider, but no documents were received;<br>-Could not provide Staff #5's shifts worked and corresponding MARs on 2/25/22 as she was not | V 118 | | |

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| V 118 | Continued From page 35<br>in the office due to a headache but would send the documentation via secured email later in the day;<br>-Could not provide Clients #2 and #5's January MARs on 2/25/22 as she was not in the office due to a headache but would send the documentation via secured email later in the day;<br>-Staff #A1 was not a qualified person to teach medication administration training.<br>-Client #1's notation of Flonase 50mcg was written as an order on 11/16/21 but it was not on any MAR as it was a mistake written by the nurse practitioner and should not have been on the order list dated 11/16/21 but nobody called the nurse practitioner to follow up or question the notation;<br>-Was informed the on-line training from the neighboring local management entity as met the requirements for medication administration training by Consulting Licensed Professional-Qualified Professional;<br>-Would arrange to secure another mental health medication management provider to ensure all medication start and discontinue orders were present in the facility;<br>-Would transition to electronic MARs to ensure all MARs were kept current;<br>-When asked if there was additional information to present or comments to make during the survey exit meeting on 3/2/22, she revealed she was in the process of arranging medication administration training through a consulting firm and would provide documentation of the same (documentation of signed contract was sent via email immediately after exit conference).<br><br>Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician. | V 118 | | |

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| V 118 | Continued From page 36<br><br>Review on 2/15/22 of the first Plan of Protection written by the L-QP#2 dated 2/15/22 revealed:<br>"What immediate action will the facility take to ensure the safety of the consumers in your care? Describe your plans to make sure the above happens.<br>V120/V123: All internal and external medications are now stored separately. Staff will complete incident reports if there are medication errors.<br>V118: Staff will obtain all prescriptions and medication orders to store at the office or group home facilities. Pathways (Licensee) is in the process of switching clients to [local health provider] to ensure that orders are always present and that discontinued orders can also be obtained.<br>Pathways Director (L-QP#2) will meet with [Consulting Licensed Professional - Qualified Professional] (L-QP#2) effective 2/21/22 to make all corrections."<br><br>Review on 2/15/22 of the second Plan of Protection written by the L-QP#2 dated 2/15/22 revealed:<br>"What immediate action will the facility take to ensure the safety of the consumers in your care? Describe your plans to make sure the above happens.<br>V120/V123: All internal and external medications are now stored separately effective 12/2/21. Staff will complete incident reports if there are medication errors. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 2/21/22.<br>V118: Staff will obtain all prescriptions and medication orders to store at the office or group home facilities. Pathways is in the process of switching clients to [local health provider] to | V 118 | | |

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| V 118 | Continued From page 37<br>ensure that orders are always present and that discontinued orders can also be obtained. The switch to [local health provider] will be complete no later than 2/25/22. New clients will be enrolled in [local health provider] system upon admission. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 2/21/22."<br><br>Review on 3/2/22 of the third Plan of Protection written by the L-QP#2 dated 3/2/22 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Describe your plans to make sure the above happens.<br>V120/V123: All internal and external medications are now stored separately effective 12/2/21. Staff will complete incident reports if there are medication errors. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 2/21/22.<br>V118: Staff will obtain all prescriptions and medication orders to store at the office or group home facilities. Pathways is in the process of switching clients to [local health provider] to ensure that orders are always present and that discontinued orders can also be obtained. The switch to [local health provider] will be complete no later than 3/15/22. New clients will be enrolled in [local health provider] system upon admission. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 2/21/22."<br><br>Review on 3/2/22 of the fourth Plan of Protection written by the L-QP#2 dated 3/2/22 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Describe your plans to make sure the above | V 118 | | |

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| V 118 | Continued From page 38<br>happens.<br>V120/V123: All internal and external medications are now stored separately effective 12/2/21. Staff will complete incident reports if there are medication errors. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 3/5/22. Staff have a training scheduled 3/10/22 to ensure they are competent and compliant with all medication requirements.<br>V118: Staff will obtain all prescriptions and medication orders to store at the office or group home facilities. Pathways is in the process of switching clients to [local health provider] to ensure that orders are always present and that discontinued orders can also be obtained. The switch to [local health provider] will be complete no later than 3/3/22. New clients will be enrolled in [local health provider] system upon admission. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 3/10/22."<br><br>Clients #1, #2, #3, #4, #5, and Former Client #6 (FC#6) ranged in age from 14-17 years old. They were diagnosed with a variety of mental health needs including, but not limited to, Attention Deficit Hyperactivity Disorder, Post-Traumatic Stress Disorder, Generalized Anxiety Disorder, Bipolar Disorder, Oppositional Defiant Disorder, Major Depressive Disorder, Disruptive Mood Dysregulation Disorder, and Substance Abuse Disorders. Client histories included self-harm, cutting, suicidal ideation, aggression, assault, overdosing on pills, substance abuse, and AWOL (absent without leave). Clients #1, #2, #3, #4, #5, and FC#6 required medications for treatment of their mental health and medical diagnoses. The facility did not maintain medication orders making it impossible to determine if clients received the | V 118 | | |

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| V 118 | Continued From page 39<br>correct medications and doses. Medication administration records were not maintained as required with 96 missing initials indicating medication administration. Medications were not stored securely as evidenced by Client #2 gaining access to the medication closet when Former Staff #8 left the keys unattended and Client #4 gaining access to the medication closet when Staff #7 gave Client #4 the keys to the medications and requested Client #4 to administer pain killer to Client #1. During access to the medication closet, Client #4 took a handful of ibuprofens and shared them with Client #1. The pills remained unlocked in the facility for several days before staff learned of the situation and seized the pills. Clients #1 and #4 had significant histories of self-harm and suicidal ideation. Furthermore, Client #3 had a history of overdosing twice on pills. It cannot be determined if any other medications were missing after clients accessed the medication closet. Staff #2 and #5 administered medications at the facility despite lack of proper training. This deficiency constitutes a Type A1 rule violation for serious neglect. An administrative penalty of $5,000.00 is imposed. | V 118 | | |
| V 120 | 27G .0209 (E) Medication Requirements<br><br>10A NCAC 27G .0209 MEDICATION REQUIREMENTS<br>(e) Medication Storage:<br>(1) All medication shall be stored:<br>(A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit;<br>(B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications | V 120 | | |

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| V 120 | Continued From page 40<br>shall be kept in a separate, locked compartment or container;<br>(C) separately for each client;<br>(D) separately for external and internal use;<br>(E) in a secure manner if approved by a physician for a client to self-medicate.<br>(2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments.<br><br>This Rule is not met as evidenced by:<br>Based upon interview, record review, and observation, the facility failed to ensure medications were stored securely affecting 3 of 5 current clients (Client #1, #2, and #4) and 1 of 3 former clients (Former Client #6) and stored separately for external and internal use affecting 2 of 5 current clients (Clients #2 and #3). The findings are:<br><br>Review on 12/2/21 and 2/24/22 of Client #1's record revealed:<br>-Admitted 8/18/21;<br>-Diagnosed with Post-Traumatic Stress Disorder, Generalized Anxiety Disorder, Major Depressive Disorder, Disruptive Mood Dysregulation Disorder, Child Sexual Abuse - Victim, Child Neglect, and Cannabis Use Disorder;<br>-15 years old;<br>-Admission assessment dated 10/7/21 completed by the Qualified Professional #1 (QP#1) revealed a history of self-harm, suicidal ideation, and overdosing twice on pills. | V 120 | | |

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| V 120 | Continued From page 41<br><br>Review on 12/2/21 and 2/24/22 of Client #2's record revealed<br>-Admitted 7/26/21;<br>-Diagnosed with Post-Traumatic Stress Disorder, Oppositional Defiant Disorder, Mood Disorder, Major Depressive Disorder, and Insomnia;<br>-17 years old.<br><br>Review on 12/2/21 of Client #3's record revealed:<br>-Admitted 10/8/21;<br>-Diagnosed with Post-Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, and Disruptive Mood Dysregulation Disorder;<br>-17 years old.<br><br>Review on 12/29/21 and 2/14/22 of Client #4's record revealed:<br>-Admitted 12/3/21;<br>-Diagnosed with Post-Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, Generalized Anxiety Disorder, and Bipolar Disorder;<br>-14 years old;<br>-Undated assessment completed by the QP#1 revealed self-harm, suicidal ideation, and substance use.<br><br>Review on 12/2/21 and 12/28/21 of Former Client #6's (FC#6) record revealed:<br>-Admitted 7/28/21;<br>-Discharged 11/19/21;<br>-Diagnosed with Post-Traumatic Stress Disorder, Persistent Depressive Disorder, Unspecified Cannabis-Related Disorder, and Unspecified Stimulant-Related Disorder;<br>-16 years old.<br><br>Review on 2/24/22 of Staff #7's record revealed:<br>-Hired 8/4/21;<br>-Employed as Residential Assistant; | V 120 | | |

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| V 120 | Continued From page 42<br>-Medication Administration Training completed by consulting Registered Nurse (RN) dated 8/12/21.<br><br>Review on 12/20/21 and 12/21/21 of Former Staff #8's (FS#8) record revealed:<br>-Hired 8/26/21;<br>-Separated from employment 12/11/21;<br>-Employed as Residential Assistant;<br>-Medication Administration Training completed by consulting Registered Nurse (RN) dated 8/19/21.<br><br>Observations on 12/1/21 at approximately 3:20pm-4:00pm and 2/21/22 at approximately 10:25-11:15am revealed:<br>-The keys to the medication closet and the keys to each clients' medication lock boxes were on the same key ring in staff's possession.<br><br>Finding #1:<br>Review on 2/24/22 of a Search and Seizure Report dated 1/18/22 signed by Staff #1 and Client #1 revealed:<br>-Client #1's bedroom was searched under suspicion of contraband;<br>-The search was conducted by Staff #1 and the Associate Professional (AP);<br>-The property seized was a "bag of 14 ibuprofens (pain reliever);"<br>-"Staff flushed the pills."<br><br>Interview on 2/22/22 with Client #1 revealed:<br>-Staff #7 gave Client #4 the keys to the medication closet when Client #1 had a headache;<br>-Staff #7 instructed Client #4 to administer ibuprofen to Client #1 for her headache;<br>-Client #4 took the bottle of ibuprofen and "poured one-half the bottle into her hand;"<br>-Client #4 gave several ibuprofen pills to Client #1; | V 120 | | |

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| V 120 | Continued From page 43<br>-Client #1 denied ingesting any ibuprofen pills reporting she was scared;<br>-Client #1 hid the ibuprofen pills in her bedroom;<br>-Client #4 kept some of the ibuprofen pills for herself;<br>-Days later, Staff #1 was informed that Staff #7 had given the medication closet keys to Client #4 and that Client #4 had taken numerous ibuprofen pills from the medication closet;<br>-Staff #1 searched Client #1's bedroom;<br>-Client #1 was scared and turned in the ibuprofen pills she had been hiding to Staff #1;<br>-Did not recall the date when Client #4 had given Client #1 the ibuprofen;<br>-Believed Staff #7 was working alone when Staff #7 gave Client #4 the keys to the medication closet.<br><br>Interview on 2/18/22 with Client #4's Department of Social Services Legal Guardian revealed:<br>-Received a telephone call from Staff #1 on 1/18/22 revealing 14 ibuprofen pills were found in Client #4's bedroom during a search;<br>-Staff #1 revealed Client #4 had been given the keys to the medication closet to get medication for a peer;<br>-Client #4 was instructed to administer ibuprofen to Client #1 because Client #1 had a headache;<br>-The staff who had given the keys to Client #4 was no longer employed;<br>-Staff #1 revealed the incident was over because the staff member who gave Client #4 the keys was no longer employed.<br><br>Interview on 2/22/22 with Client #4 revealed:<br>-Had pills in her possession because Staff #7 gave her the keys to the medication closet to get some ibuprofen for Client #1 when Client #1 had a headache;<br>-Staff completed a search of her bedroom and | V 120 | | |

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| V 120 | Continued From page 44<br>found some pills;<br>-Denied taking any other medication from the medication closet despite having access to all of the medications.<br><br>Interview on 2/24/22 with Staff #1 revealed:<br>-Learned on 1/18/22 that Client #4 had access to the medication closet keys;<br>-When confronted on 1/18/22, Client #4 acknowledged she had access to the medication closet keys;<br>-Clients #1 and #4 had several pills in their possession which Staff #1 identified as ibuprofen.<br>-Did not know why Clients #1 or #4 failed to report accessing the medication closet prior to staff's discovery of the ibuprofen pills in Client #1's possession or acknowledgement by Client #4 on 1/18/22.<br><br>Attempted interviews with Staff #7 were unsuccessful. Telephone messages were left twice on 2/23/22 and once on 2/24/22 requesting a return call, but no return telephone call was received.<br><br>Finding #2:<br>Interview on 2/22/22 with Client #1 revealed:<br>-Client #1 and FC#6 accessed the keys to the medication closet and stole money when FS #8 left the keys unattended and went into the bathroom.<br><br>Interview on 2/22/22 with Client #2 revealed:<br>-Accessed the keys to the medication closet when FS#8 was not paying attention to the keys;<br>-FS#8 left the keys unattended and went into the bathroom;<br>-Client #2 took the keys, unlocked the medication closet, and took money from the closet;<br>-FC#6 was with Client #2; | V 120 | | |

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| V 120 | Continued From page 45<br>-Client #2 and FC#6 went AWOL (absent without leave) after taking the money;<br>-Did not know the exact amount of money which was taken but believed it was a few hundred dollars;<br>-Client #2 eventually returned the money to the facility;<br>-Denied taking any medications from the medication closet despite having access to all of the medications;<br>-Denied FC#6 had any medication from the facility when she went AWOL;<br>-FC#6 never returned to the facility after the AWOL;<br>-Never heard from FC#6 after the AWOL.<br><br>Interview on 2/24/22 with Staff #1 revealed:<br>-Client #2 accessed the medication closet and took "a few hundred dollars" intended for clothing allowance;<br>-Did not have any other details regarding the incident.<br><br>Attempted interviews on 12/28/21, 12/29/21, and 2/23/22 with FS#8 were unsuccessful. Voicemail messages requesting a call back were left for FS#8, but no return call was received.<br><br>Finding #3:<br>Observation on 12/1/21 at approximately 3:20pm-3:40pm of Clients #2 and #3's medication revealed:<br>-Client #2's Benzoyl Peroxide 5% (acne) and Clindamycin Phosphate 1% (acne) stored with internal medications;<br>-Client #3's Clindamycin Phosphate 1% and Olopatadine HCL 2% (eye drops) stored with internal medications.<br><br>Interviews on 12/1/21 with Staff #1 and the | V 120 | | |

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| V 120 | Continued From page 46<br><br>Associate Professional (AP) revealed:<br>-Acknowledged internal and external medications were stored together;<br>-Did not know internal and external medications were to be stored separately;<br>-Will let Licensee-Qualified Professional #2 (L-QP#2) know of the discovery of internal and external medications stored together.<br><br>Interviews on 2/14/22, 2/15/22, 2/24/22 and 3/2/22 with the L-QP#2 revealed:<br>-Several staff separated from employment during the Division of Health Service Regulation (DHSR) survey: Staff #7 on 1/16/22, and the AP on 2/4/22;<br>-Moved all external medications on 12/2/21 to ensure they were not stored with internal medications after discovery of the external and internal medications stored together by DHSR staff;<br>-Client #4 accessed the medication closet when Staff #7 gave her the keys;<br>-Client #4 was instructed by Staff #7 to administer ibuprofen to Client #1 because Client #1 had a headache;<br>-Client #4 took numerous ibuprofen pills when she had access to the medication closet and gave some of the pills to Client #1;<br>-Staff #1 handled room searches of Clients #1 and #4 to secure any remaining ibuprofen pills;<br>-Believed all ibuprofen pills were retrieved from Clients #1 and #4;<br>-Did not know who was working with Staff #7 when Staff #7 gave the medication closet keys to Client #4;<br>-Did not know details of Clients #2 and FC#6 having access to the medication closet when FC#8 left her keys unattended;<br>-FC#6 went AWOL, never returned to the facility, and was discharged; | V 120 | | |

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| V 120 | Continued From page 47<br>-When asked if there was additional information to present or comments to make during the survey exit meeting on 3/2/22, no additional information was provided by L-QP #2.<br><br>This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type A1 rule violation. | V 120 | | |
| V 123 | 27G .0209 (H) Medication Requirements<br><br>10A NCAC 27G .0209 MEDICATION REQUIREMENTS<br>(h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted.<br>.<br><br>This Rule is not met as evidenced by:<br>Based upon interview and record review, the facility failed to ensure medication errors were reported to a physician or pharmacist and properly recorded affecting 3 of 5 clients (Clients #1, #2, and #4). The findings are:<br><br>Review on 12/2/21 and 2/24/22 of Client #1's record revealed:<br>-Admitted 8/18/21;<br>-Diagnosed with Post-Traumatic Stress Disorder, Generalized Anxiety Disorder, Major Depressive | V 123 | | |

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| V 123 | Continued From page 48<br><br>Disorder, Disruptive Mood Dysregulation Disorder, Child Sexual Abuse - Victim, Child Neglect, and Cannabis Use Disorder;<br>-15 years old;<br>-No documentation of notification of contact to a physician or pharmacist regarding medication errors or having numerous ibuprofen (pain reliever) pills in her possession.<br><br>Review on 12/2/21 and 2/24/22 of Client #2's record revealed<br>-Admitted 7/26/21;<br>-Diagnosed with Post-Traumatic Stress Disorder, Oppositional Defiant Disorder, Mood Disorder, Major Depressive Disorder, and Insomnia;<br>-17 years old;<br>-No documentation of notification of contact to a physician or pharmacist regarding medication errors.<br><br>Review on 12/1/21 and 2/21/22 of Client #2's October-December, 2021 and February, 2022 MARs revealed:<br>-Zyrtec 10mg with missing 8 signatures indicating administration in October;<br>-Prilosec 20mg missing 8 signatures indicating administration in October;<br>-Vitamin D 1000 units missing 4 signatures indicating administration in October;<br>-Benzoyl Peroxide 1% missing 2 signatures indicating administration in October and 5 signatures indicating administration in February;<br>-Clindamycin Phosphate 1% missing 1 signature indicating administration in February.<br><br>Review on 12/29/21 and 2/14/22 of Client #4's record revealed:<br>-Admitted 12/3/21;<br>-Diagnosed with Post-Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, | V 123 | | |

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| V 123 | Continued From page 49<br>Generalized Anxiety Disorder, and Bipolar Disorder;<br>-14 years old;<br>-No documentation of notification of contact to a physician or pharmacist regarding medication errors or having numerous ibuprofen pills in her possession.<br><br>Review on 2/24/22 of a Search and Seizure Report dated 1/18/22 signed by Staff #1 and Client #1 revealed:<br>-Client #1's bedroom was searched and a "bag of 14 ibuprofens" was seized.<br><br>Interviews on 12/1/21 and 2/22/22 with Client #1 revealed:<br>-Took medication at the facility;<br>-Ran out of medication once and was without the medication for at least one week;<br>-Informed she could not get the medication as there were no more refills and a new order needed to be obtained;<br>-Did not recall the date or the name of the medication;<br>-Client #1 was given several ibuprofen pills from Client #4.<br><br>Interview on 2/18/22 with Client #4's Department of Social Services Legal Guardian revealed:<br>-Received a telephone call from Staff #1 on 1/18/22 revealing 14 ibuprofens were found in Client #4's bedroom during a search.<br><br>Interview on 2/22/22 with Client #4 revealed:<br>-Took medication at the facility;<br>-Sometimes staff would forget to administer medication resulting in her missing some of the medication she was prescribed;<br>-Was able to identify she was not administered all of her medication at times as determined by the | V 123 | | |

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| V 123 | Continued From page 50 | V 123 | | |

number and color of medications administered;
-Staff completed a search of her bedroom and found some pills.

Interview on 2/24/22 with Staff #1 revealed:
-Clients #1 and #4 had several pills in their possession which staff identified as ibuprofen.

Interview on 2/22/22 with Staff #5 revealed:
-Client #1 ran out of medication and did not get the medication she required;
-Staff #1 told Staff #5 that Client #1's missed medication would arrive within one week;
-Supervisors at the facility "turned a blind eye" and "did not get services for the clients;"
-Supervisors "acted like the direct care workers were the problem;"
-"Working there (Trinity House) was such a bad experience ...it was terrible."

Interviews on 2/15/22, 2/24/22 and 3/2/22 with the Licensee-Qualified Professional #2 revealed:
-Client #4 stole numerous ibuprofen pills when she had access to the medication closet and gave some to Client #1;
-Believed all ibuprofen pills were retrieved from Clients #1 and #4;
-Acknowledged Clients #1 and #4 had ibuprofen pills in their possession but could not explain why there was no documentation of notification of contact to a physician or pharmacist regarding medication errors;
-Did not have any information about Clients #1, #2, or #4's missing medications but did acknowledge it would be hard to determine due to the missing medication orders and the multiple blank spots on the MARs;
-Would make sure all medication errors be documented on incident reports in the future;
-When asked if there was additional information

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| V 123 | Continued From page 51<br>to present or comments to make during the survey exit meeting on 3/2/22, no additional information was provided by L-QP #2.<br><br>This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type A1 rule violation. | V 123 | | |
| V 131 | G.S. 131E-256 (D2) HCPR - Prior Employment Verification<br><br>G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY<br>(d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, the facility failed to access the Health Care Personnel Registry (HCPR) prior to an offer of employment affecting 3 of 11 audited staff (Staff #4, #5, and #6). The findings are:<br><br>Review on 2/24/22 of Staff #4's record revealed:<br>-Hired 12/24/21;<br>-HCPR review completed 2/1/22.<br><br>Review on 2/24/22 of Staff #5's record revealed:<br>-Hired 10/9/21;<br>-HCPR review completed 10/20/21. | V 131 | | |

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| V 131 | Continued From page 52<br><br>Review on 2/23/22 and 2/24/22 of Staff #6's record revealed:<br>-Hired 12/21/21;<br>-HCPR review completed 2/1/22.<br><br>Interviews on 2/24/22 and 3/2/22 with the Licensee-Qualified Professional #2 (L-QP#2) revealed:<br>-Several staff separated from employment during the Division of Health Service Regulation (DHSR) survey: Staff #4 on 1/25/22, Staff #5 on 1/7/22, and Staff #6 on 2/21/22;<br>-Not sure why the HCPR reviews were completed after the hire dates for Staff #4, #5, and #6;<br>-Would ensure HCPR reviews be completed and documented prior to an offer of employment in the future;<br>-When asked if there was additional information to present or comments to make during the survey exit meeting on 3/2/22, no additional information was provided by L-QP #2.<br><br>This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation. | V 131 | | |
| V 133 | G.S. 122C-80 Criminal History Record Check<br><br>G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT.<br>(a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter.<br>(b) Requirement. - An offer of employment by a | V 133 | | |

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| V 133 | Continued From page 53<br>provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared | V 133 | | |

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| V 133 | Continued From page 54<br>with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency.<br>(c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant:<br>(1) The level and seriousness of the crime.<br>(2) The date of the crime.<br>(3) The age of the person at the time of the conviction.<br>(4) The circumstances surrounding the commission of the crime, if known.<br>(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.<br>(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed. | V 133 | | |

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| V 133 | Continued From page 55<br>(7) The subsequent commission by the person of a relevant offense.<br>The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.<br>(d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for:<br>(1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual.<br>(2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section.<br>(e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious | V 133 | | |

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| V 133 | Continued From page 56<br>Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.<br>(f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor.<br>(g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met:<br>(1) The provider shall not employ an applicant | V 133 | | |

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| V 133 | Continued From page 57<br>prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10. (2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.)<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, the facility failed to request a criminal background check within five days of an offer of employment affecting 5 of 11 audited current staff (Staff #4, #5, #6, #7, and the Associate Professional) and 3 of 4 audited former staff (Former Staff #8, #10, and #11). The findings are:<br><br>Review on 2/24/22 of Staff #4's record revealed:<br>-Hired 12/24/21;<br>-Criminal background check requested 1/13/22.<br><br>Review on 2/24/22 of Staff #5's record revealed:<br>-Hired 10/9/21;<br>-No criminal background check requested.<br><br>Review on 2/23/22 and 2/24/22 of Staff #6's record revealed:<br>-Hired 12/21/21;<br>-No criminal background check requested.<br><br>Review on 2/24/22 of Staff #7's record revealed:<br>-Hired 8/4/21; | V 133 | | |

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| V 133 | Continued From page 58<br>-Criminal background check requested 8/24/21.<br><br>Review on 12/28/21 of the Associate Professional (AP) record revealed:<br>-Hired 2/7/19;<br>-Criminal background check requested 4/16/21.<br><br>Review on 12/20/21 and 12/21/21 of Former Staff #8's record revealed:<br>-Hired 8/26/21;<br>-Separated from employment 12/11/21;<br>-Criminal background check requested 12/21/21.<br><br>Review on 12/28/21 and 2/24/21 of Former Staff #10's record revealed:<br>-Hired 12/16/20;<br>-Rehired 6/30/21;<br>-No documentation of separation date between 12/16/20 and 6/30/21;<br>-Separated from employment 9/20/21;<br>-Criminal background check requested 2/1/21.<br><br>Review on 12/28/21 and 2/24/22 of Former Staff #11's record revealed:<br>-Hired 2/1/20;<br>-Rehired 9/29/21;<br>-No documentation of separation date between 2/1/20 and 9/29/21;<br>-Separated from employment 12/18/21;<br>-Criminal background checks requested 7/1/20 and 12/21/21.<br><br>Interviews on 12/21/21, 2/24/22, and 3/2/22 with the Licensee-Qualified Professional #2 (L-QP#2) revealed:<br>-Several staff separated from employment during the Division of Health Service Regulation (DHSR) survey: Staff #4 on 1/25/22, Staff #5 on 1/7/22, Staff #6 on 2/21/22, Staff #7 on 1/16/22, and the AP on 2/4/22; | V 133 | | |

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| V 133 | Continued From page 59<br>-Was unable to identify initial dates of separation for Former Staff #10 and #11;<br>-Acknowledged criminal background checks were requested late for several staff but could not identify the reason;<br>-Not sure why there was missing criminal background checks on several staff members;<br>-Did request criminal background checks on 12/21/21 after DHSR staff requested the documentation;<br>-Would ensure criminal background checks be requested within 5 days of an offer of employment in the future;<br>-When asked if there was additional information to present or comments to make during the survey exit meeting on 3/2/22, no additional information was provided by L-QP #2.<br><br>This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation. | V 133 | | |
| V 293 | 27G .1701 Residential Tx. Child/Adol - Scope<br><br>10A NCAC 27G .1701 SCOPE<br>(a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility.<br>(b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section.<br>(c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or | V 293 | | |

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| V 293 | Continued From page 60<br>substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services.<br>(d) The children or adolescents served shall require the following:<br>(1) removal from home to a community-based residential setting in order to facilitate treatment; and<br>(2) treatment in a staff secure setting.<br>(e) Services shall be designed to:<br>(1) include individualized supervision and structure of daily living;<br>(2) minimize the occurrence of behaviors related to functional deficits;<br>(3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint;<br>(4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and<br>(5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting.<br>(f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care.<br><br>This Rule is not met as evidenced by:<br>Based on interview, record review, and | V 293 | | |

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| V 293 | Continued From page 61<br>observation, the facility failed to provide the necessary level of supervision and structure to provide intensive supervision, active therapeutic treatment, and interventions with a system of care affecting 5 of 5 current clients (Clients #1, #2, #3, #4, and #5) and 3 of 3 former clients (Former Clients #6, #7, and #8). The findings are:<br><br>CROSS REFERENCE: 10A NCAC 27G .0202 Personnel Requirements (V107)<br>Based on interview and record review, the facility failed to ensure a written job description was present in each staff member's file affecting 3 of 11 audited current staff (Staff #2, #4, and #5) and 3 of 4 audited former staff (Former Staff #8, #9, and #10) and failed to ensure each staff member met the minimum education requirements for their position affecting 5 of 11 audited current staff (Staff #3, #4, #5, #6, and #7) and 1 of 4 audited former staff (Former Staff #11).<br><br>CROSS REFERENCE: 10A NCAC 27G .0202 Personnel Requirements (V108)<br>Based on interview and record review, the facility failed to provide required training affecting 11 of 11 audited current staff (Staff #1, #2, #3, #4, #5, #6, #7, Associate Professional, Qualified Professional #1, Licensed Professional, and Licensee-Qualified Professional #2) and 4 of 4 audited former staff (Former Staff #8, #9, #10, and #11). The findings are:<br><br>CROSS REFERENCE: 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109)<br>Based on interview and record review, 3 of 3 qualified professionals (Qualified Professional #1, Licensed Professional, and Licensee-Qualified Professional #2) failed to demonstrate the knowledge, skills, and abilities required by the | V 293 | | |

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| V 293 | Continued From page 62<br>population served.<br><br>CROSS REFERENCE: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112)<br>Based on interview and record review, the facility failed to develop and implement treatment strategies to meet the needs of the clients affecting 5 of 5 current clients (Clients #1, #2, #3, #4, and #5) and 1 of 3 former clients (Former Client #7).<br><br>CROSS REFERENCE: General Statute 131E-256 Health Care Personnel Registry (V131)<br>Based on interview and record review, the facility failed to access the Health Care Personnel Registry (HCPR) prior to an offer of employment affecting 3 of 11 audited staff (Staff #4, #5, and #6).<br><br>CROSS REFERENCE: General Statute 122C-80 Criminal History Record Check (V133)<br>Based on interview and record review, the facility failed to request a criminal background check within five days of an offer of employment affecting 5 of 11 audited current staff (Staff #4, #5, #6, #7, and the Associate Professional) and 3 of 4 audited former staff (Former Staff #8, #10, and #11).<br><br>CROSS REFERENCE: 10A NCAC 27G .1702 Requirements of Qualified Professionals (V294)<br>Based on interview and record review, the Qualified Professional #1 (QP#1) failed to perform clinical and administrative responsibilities a minimum of ten hours each week at least 70% of the time when adolescents were awake and present.<br><br>CROSS REFERENCE: 10A NCAC 27G .1703 | V 293 | | |

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| V 293 | Continued From page 63<br><br>Requirements for Associate Professionals (V295)<br>Based on interview and record review, the facility failed to maintain one staff who met the requirements of an Associate Professional.<br><br>CROSS REFERENCE: 10A NCAC 27G .1704<br>Minimum Staffing Requirements (V296)<br>Based on interview, record review, and observation, the facility failed to ensure minimum staffing ratios of two staff for up to four adolescents.<br><br>CROSS REFERENCE: 10A NCAC 27G .1705<br>Requirements of Licensed Professionals (V297)<br>Based on interview and record review, the Licensed Professional failed to provide face to face clinical consultation at least four hours each week.<br><br>CROSS REFERENCE: 10A NCAC 27G .0603<br>Incident Response Requirements for Category A and B Providers (V366)<br>Based on interview and record review, the facility failed to implement their policy governing their response to Level I, II, and III incidents.<br><br>CROSS REFERENCE: 10A NCAC 27G .0604<br>Incident Reporting Requirements for Category A and B Providers (V367)<br>Based on interview and record review, the facility failed to notify the local management entity of all Level II incidents within 72 hours of becoming aware of the incidents.<br><br>CROSS REFERENCE: 10A NCAC 27G .0304<br>Facility Design and Equipment (V774)<br>Based on interview, record review, and observation, the facility was not maintained with minimum furnishings affecting 2 of 2 clients (Clients #2 and #3). | V 293 | | |

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| V 293 | Continued From page 64<br><br>Review on 2/15/22 of the first Plan of Protection written by the Licensee-Qualified Professional (L-QP#2) dated 2/15/22 revealed:<br>"What immediate action will the facility take to ensure the safety of the consumers in your care? Describe your plans to make sure the above happens.<br>V107/108: Pathways Group Homes (Licensee) Director (L-QP#2) will ensure that job descriptions and education are in the files of all employees at Pathways Group Homes. All staff will be trained if a client exhibits behaviors such as sexualized, AWOLS (absent without leave), etc.<br>V109: QP (Qualified Professional) (QP#1) will be responsible for assisting the director in getting staffed trained for client behaviors. QP (QP#1) will need to update treatment plans in accordance with goals that line up with the behaviors of the client.<br>V110: It was brought to a lead staff member's attention after taking a 10-minute break that another staff working with them fell asleep on shift. The staff was written up for falling asleep and the situation was rectified. Supervision is the most important component, and the director and staff will work hard to make sure the client's needs and supervision are continuously met.<br>V112: Treatment plans will be updated to reflect client's current behaviors. [Consulting Licensed Professional-Qualified Professional] (Consulting LP-QP) will be providing oversight and consultation to ensure that treatment plans are up to par.<br>V133: All staff members will have nurse aid registries completed before their date of hire. Criminal background checks will also be completed and maintained in the employee's file.<br>V294: Our QP (QP#1) will complete 10 hours in the group home as required. Pathways Director | V 293 | | |

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| V 293 | Continued From page 65<br>has scheduled a phone conference for [QP#1] for 2/15/22 to address all concerns.<br>V296: Pathways Group Homes will continue to hire and complete scheduling that will allow two people to be maintained on each shift. In the event that there is a call out, there is a proper chain of command that will be utilized to ensure that coverage needs are met.<br>V297: The LP (Licensed Professional) will complete their hours in person at the group home unless it is not possible due to COVID exposure. In the event that there is a COVID exposure, LP will complete therapy via telehealth and not via phone call. [Consulting LP-QP] will be providing oversight and consultation to ensure that LP meets all requirements.<br>V367: Incident reports will be completed within 72 hours and incident reports will be completed for all incidents that occur in the facility. Staff are provided paper copies of incident reports to complete on shift when an incident occurs.<br>V736/V774: Trinity House (Facility) has been purchased a dresser to go into the room to ensure that there is adequate storage for clothing and personal items. There are no other issues with exterior that I have been made aware of. Pathways director will ensure that house meets all requirements.<br>V293: Pathways Group Director will have [Consulting LP-QP] oversee operations to ensure that all citations are corrected. A Consultation log will be completed to document each time [Consulting LP-QP] provides supervision. With her assistance, Pathways Director will ensure that all needs are met and have appropriate channels in place going forward to ensure that these issues decrease in occurrence.<br><br>Pathways Group Homes Director will meet weekly with [Consulting LP-QP] effective 2/21/22 to make | V 293 | | |

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| V 293 | Continued From page 66<br>all corrections."<br><br>Review on 2/15/22 of the second Plan of Protection written by the L-QP#2 dated 2/15/22 revealed:<br>"What immediate action will the facility take to ensure the safety of the consumers in your care? Describe your plans to make sure the above happens.<br>V107/108: Pathways Group Homes Director will ensure that job descriptions and education are in the files of all employees at Pathways Group Homes. If any items are missing, they will all be obtained by 2/25/22. All staff will be trained if a client exhibits behaviors such as sexualized, AWOLS, etc when necessary. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 2/21/22.<br>V109: QP will be responsible for assisting the director in getting staffed trained for client behaviors. QP will need to update treatment plans in accordance with goals that line up with the behaviors of the client. Pathways director met with QP effective 2/15/22. All PCPS (person centered plans) will be updated no later than 2/25/22 reflecting new goals if applicable to reflect behaviors. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 2/21/22.<br>V110: It was brought to a lead staff member's attention after taking a 10-minute break that another staff working with them fell asleep on shift. The staff was written up for falling asleep and the situation was rectified. Supervision is the most important component, and the director and staff will work hard to make sure the client's needs and supervision are continuously met. Pathways Group Homes Director will meet weekly | V 293 | | |

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| V 293 | Continued From page 67<br>with [Consulting LP-QP] to ensure all corrections are being made effective 2/21/22.<br>V112: Treatment plans will be updated to reflect client's current behaviors. [Consulting LP-QP] will be providing oversight and consultation to ensure that treatment plans are up to par. Updates will be completed no later than 2/25/22. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 2/21/22.<br>V133: All staff members will have nurse aid registries completed before their date of hire. Criminal background checks will also be completed and maintained in the employee's file. All staff will have nurse aid registries and background checks completed no later than 2/25/22. New hires will have theirs upon hire with return on the background checks as soon as it is possible. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 2/21/22.<br>V294: Our QP will complete 10 hours in the group home as required. Pathways Director has scheduled a phone conference for [QP#1] for 2/15/22 to address all concerns. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 2/21/22.<br>V296: Pathways Group Homes will continue to hire and complete scheduling that will allow two people to be maintained on each shift. In the event that there is a call out, there is a proper chain of command that will be utilized to ensure that coverage needs are met. Staffing needs will be met no later than 2/25/22. Interviews have been scheduled and as well as training that will follow upon hire. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 2/21/22. | V 293 | | |

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| V 293 | Continued From page 68<br>V297: The LP will complete their hours in person at the group home unless it is not possible due to COVID exposure. In the event that there is a COVID exposure, LP will complete therapy via telehealth and not via phone call. [Consulting LP-QP] will be providing oversight and consultation to ensure that LP meets all requirements. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 2/21/22.<br>V367: Incident reports will be completed within 72 hours and incident reports will be completed for all incidents that occur in the facility. Staff are provided paper copies of incident reports to complete on shift when an incident occurs. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 2/21/22.<br>V736/V774: Trinity House has been purchased a dresser to go into the room to ensure that there is adequate storage for clothing and personal items. There are no other issues with exterior that I have been made aware of. Pathways director will ensure that house meets all requirements. The dresser will be fully assembled and placed in the group home no later than 2/25/22. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 2/21/22.<br>V293: Pathways Group Director will have [Consulting LP-QP] oversee operations to ensure that all citations are corrected. A Consultation log will be completed to document each time [Consulting LP-QP] provides supervision. With her assistance, Pathways Director will ensure that all needs are met and have appropriate channels in place going forward to ensure that these issues decrease in occurrence. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] | V 293 | | |

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| V 293 | Continued From page 69<br>to ensure all corrections are being made effective 2/21/22."<br><br>Review on 3/2/22 of the third Plan of Protection written by the L-QP#2 dated 3/2/22 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Describe your plans to make sure the above happens.<br>V107/108: Pathways Group Homes Director will ensure that job descriptions and education are in the files of all employees at Pathways Group Homes. If any items are missing, they will all be obtained by 2/25/22. All staff will be trained if a client exhibits behaviors such as sexualized, AWOLS, etc when necessary. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 3/10/22.<br>V109: QP will be responsible for assisting the director in getting staff trained for client behaviors. QP will need to update treatment plans in accordance with goals that line up with the behaviors of the clients. Pathways director met with QP effective 2/15/22. All PCPS will be updated no later than 3/3/22 reflecting new goals if applicable to reflect behaviors. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 3/10/22.<br>V110: It was brought to a lead staff member's attention after taking a 10-minute break that another staff working with them fell asleep on shift. The staff was written up for falling asleep and the situation was rectified. Supervision is the most important component, and the director and staff will work hard to make sure the client's needs and supervision are continuously met. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections | V 293 | | |

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| V 293 | Continued From page 70<br>are being made effective 3/10/22.<br>V112: Treatment plans will be updated to reflect client's current behaviors. [Consulting LP-QP] will be providing oversight and consultation to ensure that treatment plans are up to par. Updates will be completed no later than 3/10/22. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 2/21/22.<br>V131: All staff members will have nurse aid registries completed before their date of hire. Criminal background checks will also be completed and maintained in the employee's file. This issue will be corrected no later than 3/10/22.<br>V133: All staff members will have nurse aid registries completed before their date of hire. Criminal background checks will also be completed and maintained in the employee's file. All staff will have nurse aid registries and background checks completed no later than 2/25/22. New hires will have theirs upon hire with return on the background check as soon as it is possible. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 3/10/22.<br>V294: Our QP will complete 10 hours in the group home as required. Pathways Director has scheduled a phone conference for [QP#1] for 2/15/22 to address all concerns.<br>That these issues decrease in occurrence. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 2/21/22."<br><br>Review on 3/2/22 of the fourth Plan of Protection written by the L-QP#2 dated 3/2/22 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Describe your plans to make sure the above happens. | V 293 | | |

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| V 293 | Continued From page 71<br>V107/108: Pathways Group Homes Director will ensure that job descriptions and education are in the files of all employees at Pathways Group Homes. If any items are missing, they will all be obtained by 2/25/22. All staff will be trained if a client exhibits behaviors such as sexualized, AWOLS, etc when necessary. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 3/10/22.<br>V109: QP will be responsible for assisting the director in getting staff trained for client behaviors. QP will need to update treatment plans in accordance with goals that line up with the behaviors of the clients. Pathways director met with QP effective 2/15/22. All PCPS will be updated no later than 3/3/22 reflecting new goals if applicable to reflect behaviors. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 3/10/22.<br>V110: It was brought to a lead staff member's attention after taking a 10-minute break that another staff working with them fell asleep on shift. The staff was written up for falling asleep and the situation was rectified. Supervision is the most important component, and the director and staff will work hard to make sure the client's needs and supervision are continuously met. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 3/10/22.<br>V112: Treatment plans will be updated to reflect client's current behaviors. [Consulting LP-QP] will be providing oversight and consultation to ensure that treatment plans are up to par. Updates will be completed no later than 3/10/22. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 2/21/22. | V 293 | | |

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| V 293 | Continued From page 72<br>V131: All staff members will have nurse aid registries completed before their date of hire. Criminal background checks will also be completed and maintained in the employee's file. This issue will be corrected no later than 3/10/22.<br>V133: All staff members will have nurse aid registries completed before their date of hire. Criminal background checks will also be completed and maintained in the employee's file. All staff will have nurse aid registries and background checks completed no later than 2/25/22. New hires will have theirs upon hire with return on the background check as soon as it is possible. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 3/10/22.<br>V294: Our QP will complete 10 hours in the group home as required. Pathways Director has scheduled a phone conference for [QP#1] for 2/15/22 to address all concerns. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 3/10/22.<br>V295: Director will be sure to meet AP staffing requirements and will obtain employee's degree. This will be solved no later than 3/5/22.<br>V296: Pathways Group Homes will continue to hire and complete scheduling that will allow two people to be maintained on each shift. In the event that there is a call out, there is a proper chain of command that will be utilized to ensure that coverage needs are met. Staffing needs will be met no later than 2/25/22. Interviews have been scheduled and as well as training that will follow upon hire. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 3/10/22.<br>V297: The LP will complete their hours in person at the group home unless it is not possible due to | V 293 | | |

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| V 293 | Continued From page 73<br>COVID exposure. IN the event that there is a COVID exposure, LP will complete therapy via telehealth and not via phone call. [Consulting LP-QP] will be providing oversight and consultation to ensure that LP meets all requirements. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 3/10/22.<br>V366: Staff will all be trained and expected to step in when an incident occurs. Failure to do so will result in immediate termination. [Staff #3] and [Staff #1] are trained as NCI (North Carolina Interventions) instructors and will be able to train all staff and retrain staff if needed.<br>V367: Incident reports will be completed within 72 hours and incident reports will be completed for all incidents that occur in the facility. Staff are provided paper copies of incident reports to complete on shift when an incident occurs. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 3/10/22.<br>V736/V774: Trinity House (Facility) has been purchased a dresser to go into the room to ensure that there is adequate storage for clothing and personal items. There are no other issues with exterior that I have been made aware of. Pathways director will ensure that house meets all requirements. The dresser has been placed in the group home effective 2/25/22. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 3/10/22.<br>V293: Pathways Group Home Director will have [Consulting LP-QP] oversee operations to ensure that all citations are corrected. A Consultation log will be completed to document each time [Consulting LP-QP] provides supervision. With her assistance, Pathways Director will ensure that | V 293 | | |

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| V 293 | Continued From page 74 | V 293 | | |

all needs are met and have appropriate channels in place going forward to ensure that these issues decrease in occurrence. Pathways Group Homes Director will meet weekly with [Consulting LP-QP] to ensure all corrections are being made effective 2/21/22."

Clients #1, #2, #3, #4, #5 and Former Clients (FC) #6, #7, and #8 ranged in age from 14-17 years old. They were diagnosed with a variety of mental health needs including, but not limited to, Attention Deficit Hyperactivity Disorder, Post-Traumatic Stress Disorder, Generalized Anxiety Disorder, Bipolar Disorder, Oppositional Defiant Disorder, Major Depressive Disorder, Disruptive Mood Dysregulation Disorder, and Substance Abuse Disorders. Client #1 had a history of self-harm, cutting, AWOL (absent without leave), and suicidal ideation. Client #2 had a history of self-harm, cutting, and AWOL. Client #3 had a history of verbal and physical aggression with peers including hitting a peer's head into cement, self-harm, overdosing on pills, and AWOL. Client #4 had a history of self-harm, cutting, bullying, assault, and truancy due to substance abuse. Client #5 had a history of over 20 AWOLs prior to placement at the facility. Former Clients #6, #7, and #8 had histories of self-harm and AWOL. Despite client histories, treatment strategies were not developed to address Clients #1's self-harm and AWOL, Client #2's AWOL and sexualized behaviors, Client #3's repeated assaults, Client #4's substance abuse education, bullying and assault, Client #5's AWOL, and FC#7's repeated AWOLs. Only one staff worked at times resulting in a lack of supervision for the clients. Former Staff #8 fell asleep while on duty further limiting the supervision of clients. Furthermore, the absence of the Associate Professional, Qualified

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| V 293 | Continued From page 75<br><br>Professional #1 and Licensed Professional at the facility resulted in a lack of structure, coordination of care, and clinical treatment for all clients. As a result of the lack of supervision and clinical treatment, Clients #1, #2, #4, and FC #6 engaged in self-harm and cutting, Client #2 went AWOL for several days and engaged in unprotected sex with an unidentified male, and FC#4 and #6 went AWOL and never returned to the facility. Clients #1, #2, #4, and FC#6 did not receive medical attention after self-harming or suicidal ideation. Incident reports were not completed for several incidents making it impossible to track episodes of aggression, assault, property destruction, sexualized behaviors, or AWOL. Staff did not receive the required trainings to meet the needs of the clients. Staff had not received training in sexually aggressive youth despite Client #2 exchanging sexualized writing with a peer or running away and engaging in sexual activity with an unidentified male. Staff #2, #4, and #6 were missing multiple trainings including, but not limited to, organizational orientation, client rights, confidentiality, meeting the needs of the clients identified in the treatment plans, and infectious disease. Staff records were not maintained with signed job descriptions and education credentials for positions held. Furthermore, some staff were not screened for criminal background and Health Care Personnel Registry checks. The facility was maintained with limited furnishings in one bedroom. The Qualified Professional #1, Licensed Professional, and Licensee-Qualified Professional #2 did not identify and rectify the facility's systemic failures. This deficiency constitutes a Type A1 rule violation for serious neglect. An administrative penalty of $2,000.00 is imposed. | V 293 | | |

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| V 294 | Continued From page 76 | V 294 | | |
| V 294 | 27G .1702 Residential Tx. Child/Adol -Req. for Q P<br><br>10A NCAC 27G .1702 REQUIREMENTS OF QUALIFIED PROFESSIONALS<br>(a) Each facility shall utilize at least one direct care staff who meets the requirements of a qualified professional as set forth in 10A NCAC 27G .0104(18). In addition, this qualified professional shall have two years of direct client care experience.<br>(b) For each facility of five or less beds:<br>(1) the qualified professional specified in Paragraph (a) of this Rule shall perform clinical and administrative responsibilities a minimum of 10 hours each week; and<br>(2) 70% of the time shall occur when children or adolescents are awake and present in the facility.<br>(c) For each facility of six or more beds:<br>(1) the qualified professional specified in Paragraph (a) of this Rule shall perform clinical and administrative responsibilities a minimum of 32 hours each week; and<br>(2) 70% of the time shall occur when children or adolescents are awake and present in the facility.<br>(d) The governing body responsible for each facility shall develop and implement written policies that specify the clinical and administrative responsibilities of its qualified professional(s). At a minimum these policies shall include:<br>(1) supervision of its associate professional(s) as set forth in Rule .1703 of this Section;<br>(2) oversight of emergencies;<br>(3) provision of direct psychoeducational services to children or adolescents;<br>(4) participation in treatment planning | V 294 | | |

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| V 294 | Continued From page 77<br>meetings;<br>(5) coordination of each child or adolescent's treatment plan; and<br>(6) provision of basic case management functions.<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, the Qualified Professional #1 (QP#1) failed to perform clinical and administrative responsibilities a minimum of ten hours each week at least 70% of the time when adolescents were awake and present. The findings are:<br><br>Review on 2/14/22 of QP#1's record revealed:<br>-Hired 2/5/19;<br>-Signed job description dated 8/14/19 revealed: "...provide and/or assure completion of required training for residential assistant employees...develop task analyses and/or strategies for the implementation of goals...complete all required training and staff development activities...performing clinical and administrative responsibilities a minimum of 40 hours a week and 75% shall occur when the children or adolescents are awake and present in the facility, management of the day to day operation of the facility, supervision or paraprofessionals regarding responsibilities related to the implementation of each child or adolescents treatment plan ..."<br><br>Interviews on 12/29/21 and 2/22/22 with Client #1 revealed: | V 294 | | |

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| V 294 | Continued From page 78 | V 294 | | |

-The QP#1 did not come to the facility often;
-Only saw the QP#1 at the facility one to two times between admission and the end of December, 2021;
-The QP#1 came to the facility once every few weeks and stayed between 30-60 minutes.

Interview on 12/29/21 and 2/22/22 with Client #2 revealed:
-The QP#1 was at the facility when Client #2 was admitted in July, 2021 but had not seen her at the facility again until mid-to-late January, 2022;
-The QP#1 stayed at the facility only 30-60 minutes.

Interview on 12/29/21 with Client #3 revealed:
-The QP#1 was at the facility "every here and there" but could not elaborate on the frequency or duration.

Interview on 2/22/22 with Client #4 revealed:
-The QP#1 was at the facility "sometimes but not a lot."

Interview on 2/22/22 with Client #5 revealed:
-Did not know the QP#1.

Interview on 12/1/21 with Staff #1 revealed:
-The QP#1 comes to the facility weekly but could not identify specific times.

Interview on 2/23/22 with Staff #2 revealed:
-The QP#1 came to the facility only once since Staff #2 began working on 2/14/22;
-The QP#1 stayed about one hour in order to talk with each client.

Interview on 2/25/22 with Staff #3 revealed:
-Denied working at the facility;
-Acknowledged working at Sister Facility A;

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| V 294 | Continued From page 79<br>-Denied accepting the position of AP on or about 2/7/22.<br><br>Attempted interviews with Staff #4 were unsuccessful. Three separate telephone attempts to reach Staff #4 on 2/23/22 and 2/24/22 resulted in a telephone recording indicating the party was temporarily unavailable with the directive to try the call again later. A text message was sent on 2/23/22 at approximately 6:45pm requesting a telephone call back, but no return telephone call was received.<br><br>Interview on 2/22/22 with Staff #5 revealed:<br>-Never met the QP#1 or saw her at the facility but had primarily worked on weekends;<br>-Supervisors at the facility "turned a blind eye" and "did not get services for the clients;"<br>-Supervisors "acted like the direct care workers were the problem;"<br>-"Working there (Trinity House) was such a bad experience ...it was terrible."<br><br>Attempted interview on 2/24/22 with Staff #6 was unsuccessful. A voicemail message was left requesting a return call, but no return telephone call was received. A prior attempt had been made on 2/23/22 to the first number the L-QP#2 had provided, but the number had been an incorrect number.<br><br>Attempted interviews with Staff #7 were unsuccessful. Voicemail messages were left twice on 2/23/22 and once on 2/24/22 requesting a return call, but no return telephone call was received.<br><br>Attempted interviews on 12/28/21, 12/29/21, and 2/23/22 with Former Staff #8 (FS#8) were unsuccessful. Voicemail messages requesting a | V 294 | | |

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| V 294 | Continued From page 80 | V 294 | | |

call back were left for FS#8, but no return call was received.

Attempted interviews on 12/28/21, 12/29/21, and 2/23/22 with FS#9 were unsuccessful. Voicemail messages requesting a call back were left for FS#9, but no return call was received.

Attempted interview on 12/28/21 with FS#10 was unsuccessful. A telephone call to the number provided by the L-QP#2 revealed a message indicating the number "had not been assigned yet."

Interview on 12/28/21 with FS#11 revealed:
-The QP#1 did not come to the facility but worked from home;
-The QP#1 called in frequently to check on things at the facility;
-Direct care staff were the only staff working in the facility.

Interview on 12/1/22 with the Associate Professional (AP) revealed:
-The QP#1 came to the facility weekly;
-Could not identify how long the QP#1 remained at the facility when present.

Attempted additional interviews on 2/23/22 with the AP after she left employment were unsuccessful. Voicemail messages could not be left as the mailbox was full. A text message was sent requesting a return call, but no return telephone call was received.

Interviews on 12/28/21 and 2/16/22 with the QP#1 revealed:
-Client #4 did not receive any substance abuse prevention education while at the facility due to her discharging after only 7 weeks at the facility;

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| V 294 | Continued From page 81<br><br>-Acknowledged treatment plans did not have strategies to address the needs of clients served at the facility but could not provide an explanation for this;<br>-Completed virtual visits to the facility;<br>-Completed most of her work from the office that was not located at the facility but was located at an off-site office building;<br>-Worked when the clients were in school and only saw the clients virtually;<br>-Did not meet with the LP for clinical supervision around client care and services.<br><br>Interviews on 2/15/22 and 3/2/22 with the Licensee-Qualified Professional #2 (L-QP#2) revealed:<br>-Was aware the QP#1 needed to be present in the facility for 10 hours weekly with 70% of the time being when the clients were present and awake;<br>-Was not aware the QP#1 was not present in the facility when the clients were present;<br>-Will ensure the QP#1 is present in the facility as required in the future;<br>-When asked if there was additional information to present or comments to make during the survey exit meeting on 3/2/22, the L-QP #2 revealed the QP#1 was not in the facility due to illness related to the pandemic which lasted one to two weeks. The QP#1 would implement a log to be completed each time she worked in the facility and have the client sign the log when she met with them for future visits.<br><br>This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation. | V 294 | | |

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| V 295 | Continued From page 82 | V 295 | | |
| V 295 | 27G .1703 Residential Tx. Child/Adol - Req. for A P<br><br>10A NCAC 27G .1703 REQUIREMENTS FOR ASSOCIATE PROFESSIONALS<br>(a) In addition to the qualified professional specified in Rule .1702 of this Section, each facility shall have at least one full-time direct care staff who meets or exceeds the requirements of an associate professional as set forth in 10A NCAC 27G .0104(1).<br>(b) The governing body responsible for each facility shall develop and implement written policies that specify the responsibilities of its associate professional(s). At a minimum these policies shall address the following:<br>(1) management of the day to day day-to-day operations of the facility;<br>(2) supervision of paraprofessionals regarding responsibilities related to the implementation of each child or adolescent's treatment plan; and<br>(3) participation in service planning meetings.<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, the facility failed to maintain one staff who met the requirements of an Associate Professional. The findings are:<br><br>Review on 12/28/21 and 2/24/22 of Staff #3's record revealed:<br>-Hired 8/30/20;<br>-Employed as Residential Assistant;<br>-Signed job description dated 2/7/22 for Associate | V 295 | | |

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| V 295 | Continued From page 83<br>Professional (AP);<br>-No education credentials for position of the AP.<br><br>Review on 12/28/21 of the AP's record revealed:<br>-Hired 2/7/19.<br><br>Interview on 2/25/22 with Staff #3 revealed:<br>-Denied working at the facility;<br>-Acknowledged working at Sister Facility A;<br>-Denied accepting the position of AP on or about 2/7/22.<br><br>Interviews on 2/24/22 and 3/2/22 with the Licensee-Qualified Professional #2 (L-QP#2) revealed:<br>-Staff #3 recently accepted the position of AP signing the job description on 2/7/22 after the original AP for the facility resigned on 2/4/22;<br>-Did not know why Staff #3 denied working at the facility or accepting the position of AP;<br>-Would meet with Staff #3 again to ensure she will assume the responsibilities of AP;<br>-When asked if there was additional information to present or comments to make during the survey exit meeting on 3/2/22, no additional information was provided by L-QP #2.<br><br>This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation. | V 295 | | |
| V 296 | 27G .1704 Residential Tx. Child/Adol - Min. Staffing<br><br>10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS<br>(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 | V 296 | | |

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| V 296 | Continued From page 84<br>times.<br>(b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows:<br>(1) two direct care staff shall be present for one, two, three or four children or adolescents;<br>(2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and<br>(3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents.<br>(c) The minimum number of direct care staff during child or adolescent sleep hours is as follows:<br>(1) two direct care staff shall be present and one shall be awake for one through four children or adolescents;<br>(2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and<br>(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.<br>(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.<br>(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. | V 296 | | |

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| V 296 | Continued From page 85 | V 296 | | |

This Rule is not met as evidenced by:
Based on interview, record review, and observation, the facility failed to ensure minimum staffing ratios of two staff for up to four adolescents. The findings are:

Observation on 12/1/21 at approximately 2:40pm-3:00pm revealed:
-The Associate Professional (AP) was the only staff member at the facility with three clients.

Observation on 12/29/21 at approximately 11:40am and Interviews with the Licensee-Qualified Professional #2 (l-QP#2) and Staff #B1 revealed:
-Division of Health Service Regulation staff arrived at the facility's office but was unable to enter the office due to the front door being locked. Observation through the window next to the front door revealed facility clients sitting on the floor eating snacks. The L-QP#2 was notified via telephone call of Division of Health Service Regulation (DHSR) staff arrival. Observation through the windows revealed the clients being moved from the front office. There was a 5 to 7-minute delay in unlocking the front door to allow DHSR entry. A walk-through of the office suite revealed no clients. The L-QP#2 revealed the clients left with two staff as Client #3 was scheduled for a medical appointment with her primary care physician. The L-QP#2 further explained the clients would be gone for a while and could not return in fear of missing the medical appointment. Approximately 25 minutes later, Clients #1, #2, #3 and #4 arrived at the office with the Associate Professional (AP) and

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| V 296 | Continued From page 86<br><br>Staff #3 entering the office through the rear door. Upon request of documentation for the medical appointment, Staff #B1 revealed the appointment was cancelled and there was no documentation to review. L-QP#2 added the medical appointment cancellation was beyond their control.<br><br>Review on 12/2/21 and 2/24/22 of Client #1's record revealed:<br>-Admitted 8/18/21;<br>-Diagnosed with Post-Traumatic Stress Disorder, Generalized Anxiety Disorder, Major Depressive Disorder, Disruptive Mood Dysregulation Disorder, Child Sexual Abuse - Victim, Child Neglect, and Cannabis Use Disorder;<br>-15 years old.<br><br>Review on 12/2/21 and 2/24/22 of Client #2's record revealed<br>-Admitted 7/26/21;<br>-Diagnosed with Post-Traumatic Stress Disorder, Oppositional Defiant Disorder, Mood Disorder, Major Depressive Disorder, and Insomnia;<br>-17 years old.<br><br>Review on 12/2/21 of Client #3's record revealed:<br>-Admitted 10/8/21;<br>-Diagnosed with Post-Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, and Disruptive Mood Dysregulation Disorder;<br>-17 years old.<br><br>Review on 12/29/21 and 2/14/22 of Client #4's record revealed:<br>-Admitted 12/3/21;<br>-Diagnosed with Post-Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, Generalized Anxiety Disorder, and Bipolar Disorder; | V 296 | | |

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| V 296 | Continued From page 87<br>-14 years old.<br><br>Review on 12/2/21 and 12/28/21 of Former Client #6's (FC#6) record revealed:<br>-Admitted 7/28/21;<br>-Discharged 11/19/21;<br>-Diagnosed with Post-Traumatic Stress Disorder, Persistent Depressive Disorder, Unspecified Cannabis-Related Disorder, and Unspecified Stimulant-Related Disorder;<br>-16 years old;<br>-Treatment plan dated 10/18/21 revealed FC#6 accessed social media without permission.<br><br>Review on 12/2/21 and 12/28/21 of FC#7's record revealed:<br>-Admitted 7/28/21;<br>-Discharged 10/7/21<br>-Diagnosed with Diagnoses Post-Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder, and Gender Identity Disorder in Adolescents or Youth;<br>-17 years old.<br><br>Review on 12/20/21 and 12/21/21 of Former Staff #8's (FS#8) record revealed:<br>-Hired 8/26/21;<br>-Separated from employment 12/11/21;<br>-Employed as Residential Assistant;<br>-Written disciplinary notice for falling asleep on 10/4/21 while on duty with clients present.<br><br>Review on 12/2/21 of the written service call report of law enforcement/emergency service departments provided by the county's 911 Coordinator dated 11/22/21 revealed:<br>-Former Staff #8 (FS#8) required law enforcement assistance during a physical altercation between Clients #2 and #3 while FS#8 worked alone; | V 296 | | |

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| V 296 | Continued From page 88<br>-FC#7 went AWOL requiring 6 calls to law enforcement in less than one week (September, 2021).<br><br>Interviews on 12/1/21, 12/29/21, and 2/22/22 with Client #1 revealed:<br>-Only one staff worked most shifts because the facility was short-staffed due to staff quitting or not wanting to work;<br>-Was taken out the back door of the office on 12/29/21 by the AP when there was a knock at the front door. The AP and four clients went to the facility to pick up Staff #3 and then returned to the office. They never attempted to go on a medical appointment.<br><br>Interviews on 12/1/21, 12/29/21, and 2/22/22 with Client #2 revealed:<br>-Was supposed to be two staff working each shift but there was only one staff working most shifts;<br>-Recalled only one staff was present when she went AWOL with FC#6. Client #2 was gone for several days and had unprotected sex with a male peer but then returned to the facility. FC#6 never returned to the facility and was discharged;<br>-Only one staff was working when she got into a physical altercation with Client #3;<br>-Was taken out the back door of the office on 12/29/21 with her peers when there was a knock at the front door. The AP and four clients went to the facility to pick up Staff #3 and then returned to the office. They never attempted to go on a medical appointment.<br><br>Interviews on 12/1/21 and 12/29/21 with Client #3 revealed:<br>-One or two staff members worked each shift;<br>-Was taken out the back door of the office on 12/29/21 by the AP when there was a knock at the front door. Was told they needed to go to a | V 296 | | |

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| V 296 | Continued From page 89 | V 296 | | |

local superstore. The AP and four clients did not go to a local superstore but drove directly to the facility to pick up Staff #3 and returned to the office.

Interviews on 12/29/21 and 2/22/22 with Client #4 revealed:
-One staff worked most shifts.
-Was taken out the back door of the office on 12/29/21 with her peers when there was a knock at the front door. The AP and four clients went to the facility to pick up Staff #3. They went directly to the facility and returned to the office immediately upon picking up Staff #3.

Interview on 2/24/22 with Staff #1 revealed:
-Completed a written disciplinary notice on 10/4/21 when FS#8 fell asleep while on duty with clients present;
-Was working with FS#8 at the time of the incident;
-Observed FS#8 sleeping in the facility.

Interview on 2/23/22 with Staff #2 revealed:
-Worked second shift alone every Monday.

Interview on 2/25/22 with Staff #3 revealed:
-Denied working at the facility;
-Acknowledged working at Sister Facility A;
-Denied accepting the position of AP on or about 2/7/22.

Interview on 2/22/22 with Staff #5 revealed:
-Worked by herself most times;
-First shift on weekends and third shift were generally staffed by only one staff member;
-Supervisors at the facility "turned a blind eye" and "did not get services for the clients:"
-Supervisors "acted like the direct care workers were the problem;"

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| V 296 | Continued From page 90<br>-"Working there (Trinity House) was such a bad experience ...it was terrible."<br><br>Interview on 12/28/21 with Former Staff #11 revealed:<br>-"Worked alone 90% of the time;"<br>-Worked alone when FC#7 went AWOL repeatedly;<br>-Did not feel she had the support she needed when she worked alone.<br><br>Interview on 12/1/21 with the AP revealed:<br>-Was the only staff working with three clients when DHSR arrived at the facility on 12/1/21.<br><br>Attempted additional interviews on 2/23/22 with the AP after she left employment were unsuccessful. Voicemail messages could not be left as the mailbox was full. A text message was sent requesting a return call, but no return telephone call was received.<br><br>Refer to V294 for multiple interview attempts with Staff #4, #6, #7, Former Staff #8, #9, and #10.<br><br>Interviews on 12/2/21, 12/28/21, 12/29/21, 2/14/22, and 3/2/22 with the L-QP#2 revealed:<br>-Did not know the specifics about FS#8 falling asleep while on duty with clients present as she did not handle to situation;<br>-Staff #1 would have information on the 10/4/21 incident involving FS#8 as she completed the written disciplinary notice;<br>-Staff #1 was promoted to House Manager on 2/22/22;<br>-Tried to schedule two staff to work each shift but sometimes had difficulty with staffing ratios due to staff calling out resulting in only one staff at times;<br>-Was aware of the number of calls seeking law enforcement assistance for FC#7 due to | V 296 | | |

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| V 296 | Continued From page 91<br>continued AWOLS but "there was nothing we could do to stop the AWOLs;"<br>-FC#6 was discharged from the facility after going AWOL and not returning to the facility. The discharge date was 11/19/21;<br>-When asked if there was additional information to present or comments to make during the survey exit meeting on 3/2/22, no additional information was provided by L-QP #2.<br><br>This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation. | V 296 | | |
| V 297 | 27G .1705 Residential Tx. Child/Adol - Req. for L P<br><br>10A NCAC 27G .1705 REQUIREMENTS OF LICENSED PROFESSIONALS<br>(a) Face to face clinical consultation shall be provided in each facility at least four hours a week by a licensed professional. For purposes of this Rule, licensed professional means an individual who holds a license or provisional license issued by the governing board regulating a human service profession in the State of North Carolina. For substance-related disorders this shall include a licensed Clinical Addiction Specialist or a certified Clinical Supervisor.<br>(b) The consultation specified in Paragraph (a) of this Rule shall include:<br>(1) clinical supervision of the qualified professional specified in Rule .1702 of this Section;<br>(2) individual, group or family therapy services; or<br>(3) involvement in child or adolescent specific treatment plans or overall program issues. | V 297 | | |

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| V 297 | Continued From page 92<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, the Licensed Professional (LP) failed to provide face to face clinical consultation at least four hours each week. The findings are:<br><br>Review on 2/14/22 of the LP's record revealed:<br>-Hired 9/30/20;<br>-Signed job description dated 7/8/21 revealed: " ...face to face clinical consultation shall be provided in each facility at least 4 hours a week ...must provide clinical supervision to the Qualified Professional monthly ...update treatment team on the progress of therapy with the clients ...involvement in the children or adolescents specific treatment plans and overall programming ..."<br><br>Review on 1/11/22 of the LP's weekly notes for period 10/1/21 through 1/10/22 revealed:<br>-Notes reflecting sessions with Clients #1, #2, #3, #4, and Former Client #5 ranging from 0 (refusals) to 40 minutes in duration;<br>-There was no indication in the notes if sessions were held face-to-face or via telehealth.<br><br>Interviews on 12/1/21, 12/29/21, and 2/22/22 with Client #1 revealed:<br>-Saw the LP one time at the facility;<br>-Saw the LP one time at the office;<br>-Spoke to the LP one time on the telephone for no more than 10 minutes;<br>-Met with the LP on-line for virtual sessions with the length of the session being dictated by how long Client #1 wanted to speak to the LP. | V 297 | | |

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| V 297 | Continued From page 93<br><br>Interviews on 12/29/21 and 2/22/22 with Client #2 revealed:<br>-Had difficulty recalling the last time the LP was at the facility but thought it was around Thanksgiving;<br>-Saw the LP virtually or spoke with her on the telephone - with most sessions generally on the telephone;<br>-Time spent with the LP varied but it was "never more than a few minutes."<br><br>Interviews on 12/1/21 and 12/29/21 with Client #3 revealed:<br>-The LP "comes every other month" to the facility;<br>-The only contact with the LP during the month of December, 2021 was one virtual visit.<br><br>Interview on 2/22/22 with Client #4 revealed:<br>-Only saw the LP twice - once at the facility and once virtually - each time lasting approximately 25 minutes.<br><br>Interview on 2/22/22 with Client #5 revealed:<br>-Met with a therapist virtually but the therapist did not come to the facility;<br>-Could not identify how long she spoke with the therapist;<br>-Could not identify if the therapist was the LP.<br><br>Interview on 12/1/21 with Staff #1 revealed:<br>-The LP came to the facility weekly on Wednesday afternoons but could not identify why the LP was not currently present despite it being a Wednesday afternoon.<br><br>Interview on 2/23/22 with Staff #2 revealed:<br>-The LP did not come to the facility ;<br>-The LP provided weekly therapy virtually;<br>-The length of time each client spent with the LP depended on how long the client wanted to | V 297 | | |

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| V 297 | Continued From page 94<br>remain in the session.<br><br>Interview on 2/22/22 with Staff #5 revealed:<br>-Never met the LP or saw her at the facility but had primarily worked on weekends;<br>-The clients needed therapy but did not know if they ever saw a therapist;<br>-Supervisors at the facility "turned a blind eye" and "did not get services for the clients;"<br>-Supervisors "acted like the direct care workers were the problem;"<br>-"Working there (Trinity House) was such a bad experience ...it was terrible."<br><br>Interview on 12/28/21 with Former Staff #11 revealed:<br>-The LP did not come to the facility;<br>-The LP called the facility and spoke with each client for a few minutes;<br>-Direct care staff were the only staff working in the facility.<br><br>Interview on 12/1/22 with the Associate Professional (AP) revealed:<br>-The LP came to the facility weekly on Wednesday afternoons or talked with the clients over the telephone;<br>-The LP was last at the facility about two weeks ago but had not returned since;<br>-"Maybe she was sick".<br><br>Interview on 2/16/22 with the Qualified Professional #1 (QP#1) revealed:<br>-The LP did not provide therapy at the facility due to the pandemic but did provide therapy via telehealth appointments;<br>-Did not meet with the LP for clinical supervision.<br><br>Interview on 1/10/22 with the LP revealed:<br>-Provided LP services at the facility on | V 297 | | |

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Wednesdays arriving between 3-4pm weekly;
-Time spent at the facility varied depending upon which client(s) wanted to meet for therapy;
-Missed sessions for three weeks at the end of November, 2021 lasting into December, 2021 due to medical issues of surgery and illness related to the pandemic;
-Could not identify if there was any LP filling in during the time of illness replying "not to my knowledge;"
-All clinical notes were kept in a book in her possession;
-Upon request of clinical notes for the past three months, the LP revealed she could not provide them within the 6-hour window presented by Division of Health Service Regulation (DHSR) staff but would be able to provide them within 24 hours;
-Acknowledged providing telehealth appointments "a couple of times" due to the pandemic but revealed she did not document within the therapy note if the session was virtual or in person.

Additional attempted interviews with the LP were unsuccessful. A request was made by DHSR on 2/14/22 at 11:45am for the L-QP#2 to arrange a telephone interview between Division of Health Service Regulation (DHSR) staff and the LP. Despite attempts to arrange a telephone interview, no telephone call was received from the LP. An additional attempt was made by DHSR on 2/16/22 at 9:50am via telephone call to the LP. The following message was on the LP's telephone: "The wireless customer you are calling is not available. Please try your call again later."

Interviews on 2/15/22 and 3/2/22 with the L-QP#2 revealed:
-Was not aware the LP was not present at the

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| V 297 | Continued From page 96<br>facility to conduct therapy with the clients;<br>-Was not acceptable that the LP was not present at the facility;<br>-Would ensure the LP was in the facility weekly to meet with each client for confidential therapy sessions in the future;<br>-When asked if there was additional information to present or comments to make during the survey exit meeting on 3/2/22, the L-QP #2 revealed the LP was not in the facility due to illness related to the pandemic but did not identify a time frame. The L-QP#2 would be looking to hire a different LP in the coming weeks.<br><br>This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation. | V 297 | | |
| V 366 | 27G .0603 Incident Response Requirments<br><br>10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS<br>(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:<br>(1) attending to the health and safety needs of individuals involved in the incident;<br>(2) determining the cause of the incident;<br>(3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;<br>(4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;<br>(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; | V 366 | | |

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| V 366 | Continued From page 97<br>(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<br>(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.<br>(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.<br>(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:<br>(1) immediately securing the client record by:<br>(A) obtaining the client record;<br>(B) making a photocopy;<br>(C) certifying the copy's completeness; and<br>(D) transferring the copy to an internal review team;<br>(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 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:<br>(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; | V 366 | | |

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| V 366 | Continued From page 98<br>(B) gather other information needed;<br>(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<br>(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<br>(3) immediately notifying the following:<br>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;<br>(B) the LME where the client resides, if different;<br>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;<br>(D) the Department;<br>(E) the client's legal guardian, as applicable; and<br>(F) any other authorities required by law. | V 366 | | |

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| V 366 | Continued From page 99 | V 366 | | |

This Rule is not met as evidenced by:
Based on interview and record review, the facility failed to implement their policy governing their response to Level I, II, and III incidents. The findings are:

Review on 2/15/22 of the undated incident reporting policy revealed:
-"Reporting of any incident, unusual occurrence, or medication error: after appropriate action is taken to remedy the problem and to ensure the safety, well-being and care of those individuals who are directly involved in the incident, then a report shall be completed. The report should be on the standardized incident reporting form. The report shall be completed in detain and shall include all pertinent facts such as time, place, persons involved, witnesses, extent of injury or damages and methods of remedy. The copy shall be placed in the incident file at the facility ..."

Review on 12/2/21 and 2/24/22 of Client #1's record revealed:
-Treatment plan dated 1/12/22 revealed Client #1 inflicted self-harming wounds which were discovered on 12/31/21.

Review on 12/2/21 and 2/24/22 of Client #2's record revealed
-Treatment plan dated 12/27/21 revealed Client #2 engaged in verbal aggression, was attacked by a peer (Client #3), and exchanged sexualized writings with a peer (with no identification of the peer).

Review on 12/29/21 and 2/14/22 of Client #4's record revealed:

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| V 366 | Continued From page 100<br>-Treatment plan dated 12/28/21 revealed episodes of verbal aggression towards peers and staff and bullying peers.<br><br>Review on 12/2/21 and 12/28/21 of Former Client #6's (FC#6) record revealed:<br>-Treatment plan dated 10/18/21 revealed FC#6 accessed social media without permission.<br><br>Review on 12/17/21 and 2/14/22 of the facility's incident reports revealed:<br>-No incident report completed on Client #1's self-harming wounds discovered on 12/31/21;<br>-No incident report completed on Client #4's self-harming wounds reported to her legal guardian on 1/4/22;<br>-No incident reports completed on Client #2's verbal aggression, attack by a peer (Client #3), or exchange of sexualized writings;<br>-No incident report completed on Client #4's verbal aggression and bullying;<br>-No incident report completed on FC#6's social media use.<br><br>Review on 12/20/21 of the North Carolina Incident Response Improvement System (NC IRIS) revealed:<br>-Report dated 7/30/21 for FC#8 with alcohol bottle and drug paraphernalia ;<br>-Report dated 8/4/21 for FC#7 locked in the bedroom with refusals to open the door;<br>-Report dated 9/25/21 for FC#7 AWOL;<br>-Report dated 9/27/21 for FC#8 AWOL after property destruction;<br>-Report dated 11/14/21 for Client #2 AWOL;<br>-Report dated 11/14/21 for FC#6 AWOL;<br>-Report dated 12/13/21 for Client #3 mental health needs.<br><br>Interview on 2/22/22 with Client #1 revealed: | V 366 | | |

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| V 366 | Continued From page 101<br>-Had inflicted self-harming wounds on her body which were covered by clothing. The wounds, which were healing, were found on 12/31/21.<br><br>Interview on 2/22/22 with Client #2 revealed:<br>-Was in a physical fight with Client #3 but could not identify the date.<br>-Would not discuss the sexualized writings.<br><br>Interview on 2/18/22 with Client #4's Department of Social Services Legal Guardian revealed:<br>-Was notified on 1/3/22 that Client #4 was found to have wounds from previous cutting episodes which were healing. Client #4 had all items used from cutting removed from her possession.<br><br>Interview on 2/22/22 with Client #4 revealed:<br>-Engaged in cutting behaviors at the facility and was able to conceal the wounds from cutting because they were hidden by clothing.<br><br>Interview on 2/22/22 with Staff #5 revealed:<br>-Clients #1 and #4 were involved in cutting themselves to make designs in their skin.<br>-Supervisors at the facility "turned a blind eye" and "did not get services for the clients;"<br>-Supervisors "acted like the direct care workers were the problem;"<br>-"Working there (Trinity House) was such a bad experience ...it was terrible."<br><br>Interviews on 2/14/22 and 3/2/22 with the L-QP#2 revealed:<br>-Could not identify why incident reports were not completed regarding Client #1, #2, #4, and FC#6;<br>-Clients #1 and #4 did not receive any medical attention after the discovery of the self-harming wounds on 12/31/21 and on or about 1/3/22, respectively;<br>-Would work with Staff #1 to ensure all incidents | V 366 | | |

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| V 366 | Continued From page 102<br>were recorded in the future;<br>-When asked if there was additional information to present or comments to make during the survey exit meeting on 3/2/22, no additional information was provided by L-QP #2.<br><br>This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation. | V 366 | | |
| V 367 | 27G .0604 Incident Reporting Requirements<br><br>10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS<br>(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:<br>(1) reporting provider contact and identification information;<br>(2) client identification information;<br>(3) type of incident;<br>(4) description of incident;<br>(5) status of the effort to determine the cause of the incident; and<br>(6) other individuals or authorities notified or responding. | V 367 | | |

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| V 367 | Continued From page 103<br>(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:<br>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or<br>(2) the provider obtains information required on the incident form that was previously unavailable.<br>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:<br>(1) hospital records including confidential information;<br>(2) reports by other authorities; and<br>(3) the provider's response to the incident.<br>(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).<br>(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:<br>(1) medication errors that do not meet the definition of a level II or level III incident; | V 367 | | |

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| V 367 | Continued From page 104<br>(2) restrictive interventions that do not meet the definition of a level II or level III incident;<br>(3) searches of a client or his living area;<br>(4) seizures of client property or property in the possession of a client;<br>(5) the total number of level II and level III incidents that occurred; and<br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, the facility failed to notify the local management entity of all Level II incidents within 72 hours of becoming aware of the incidents. The findings are:<br><br>Review on 12/2/21 and 2/24/22 of Client #1's record revealed:<br>-Treatment plan dated 1/12/22 revealed Client #1 pierced her nose (date unknown) and went AWOL (absent without leave), returned to the facility, and displayed suicidal ideation but refused to be evaluated at a local hospital on 12/31/21.<br><br>Review on 12/2/21 and 2/24/22 of Client #2's record revealed<br>-Treatment plan dated 12/27/21 revealed Client #2 eloped from the facility for several days and | V 367 | | |

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| V 367 | Continued From page 105<br>had unprotected sex with an unidentified male.<br><br>Review on 12/2/21 and 12/28/21 of Former Client #6's (FC#6) record revealed:<br>-Treatment plan dated 10/18/21 revealed FC#6 pierced her nose (date unknown).<br><br>Review on 12/2/21 and 2/22/22 of audio and written service call reports of law enforcement/emergency service departments provided by the county's 911 Coordinator revealed:<br>-There were 16 calls for service to the facility from 7/30/21-11/22/21 (3 civil disturbance, 2 assault, 1 prowler, 10 missing person reports);<br>-There were 6 calls for service to the facility from 12/1/21-2/21/22 (2 missing person, 2 psychiatric emergencies, 1 motor vehicle accident, 1 welfare check);<br>-Call on 9/6/21 by Staff #1 for FC#8 engaged in a behavioral outburst including property destruction;<br>-2 calls on 9/24/21 by Staff #1 for FC#7 repeated AWOLs;<br>-2 calls on 9/26/21 by Former Staff #11 (FS#11) for FC#7 repeated AWOLs;<br>-Call on 9/29/21 by Former Staff #8 (FS#8) for FC#7 and FC#8 AWOL;<br>-Call on 9/30/21 by Staff #1 for FC#7 AWOL;<br>-Call on 10/1/21 by Staff #1 for FC#6 AWOL;<br>-Call on 11/22/21 by FS#8 regarding Client #1 assaulting FS#8 by hitting her on the head with a telephone;<br>-Call on 1/4/22 by Staff #5 for a welfare check after assault involving Clients #3 and #4.<br><br>Review on 12/20/21 of the North Carolina Incident Response Improvement System (NC IRIS) revealed:<br>-Report dated 7/30/21 for FC#8 with alcohol bottle and drug paraphernalia ; | V 367 | | |

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| V 367 | Continued From page 106<br>-Report dated 8/4/21 for FC#7 locked in the bedroom with refusals to open the door;<br>-Report dated 9/25/21 for FC#7 AWOL;<br>-Report dated 9/27/21 for FC#8 AWOL after property destruction;<br>-Report dated 11/14/21 for Client #2 AWOL;<br>-Report dated 11/14/21 for FC#6 AWOL;<br>-Report dated 12/13/21 for Client #3 mental health needs.<br><br>Review on 12/17/21 of the facility's Incident Reports revealed:<br>-No Level II incident reports for the calls to local law enforcement on 9/24/21 (twice), 9/26/21 (twice), 9/29/21, 9/30/21, 10/1/21, 11/22/21, and 1/4/22;<br>-No Level II incident report when Clients #2, #4, and FC#6 each pierced their own noses;<br>-Level II incident report dated 12/31/21 when Client #4 went AWOL, returned to the facility, and displayed suicidal ideation.<br><br>Interview on 2/22/22 with Client #1 revealed:<br>-Pierced her nose while at the facility but would not provide details regarding the piercing;<br>-Refused to go to the hospital for evaluation after displaying suicidal ideation on 12/31/21.<br><br>Interviews on 12/1/21 and 2/22/22 with Client #2 revealed:<br>-Eloped with a peer and had unprotected sex with an unidentified male.<br><br>Interview on 2/18/22 with Client #4's Department of Social Services Legal Guardian revealed:<br>-Client #4 pierced her nose with a thumbtack while at the facility.<br><br>Interview on 2/22/22 with Client #4 revealed:<br>-Pierced her nose with a thumbtack while at the | V 367 | | |

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| V 367 | Continued From page 107<br>facility;<br>-Received the thumbtack from facility staff to use to hang pictures in her room.<br><br>Interviews on 12/1/21 and 2/24/22 with Staff #1 revealed:<br>-Law enforcement was called to the facility for clients' behaviors.<br><br>Interview on 12/28/21 with Former Staff #11 revealed:<br>-Called law enforcement when FC#7 went AWOL repeatedly.<br><br>Interviews on 2/14/22 and 3/2/22 with the L-QP#2 revealed:<br>-Could not identify why the Level II incidents were not completed;<br>-Was not aware of the number of calls seeking law enforcement assistance for FC#7 due to continued AWOLs but "there was nothing we could do to stop the AWOLs;"<br>-Would work with Staff #1 to ensure all incidents were recorded correctly in the future;<br>-When asked if there was additional information to present or comments to make during the survey exit meeting on 3/2/22, no additional information was provided by L-QP #2.<br><br>This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation. | V 367 | | |
| V 512 | 27D .0304 Client Rights - Harm, Abuse, Neglect<br><br>10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION<br>(a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance | V 512 | | |

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| V 512 | Continued From page 108<br>with G.S. 122C-66.<br>(b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter.<br>(c) Goods or services shall not be sold to or purchased from a client except through established governing body policy.<br>(d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter.<br>(e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, 2 of 11 audited staff (Staff #6 and Licensee-Qualified Professional #2) neglected and failed to protect 1 of 5 clients (Client #4) from physical harm. The findings are:<br><br>Review on 2/24/22 of Staff #4's record revealed:<br>-Hired 12/24/21;<br>-Employed as Residential Assistant;<br>-No documentation of training in alternatives to restrictive intervention, seclusion, physical restraint, and isolation time-out.<br><br>Review on 2/23/22 and 2/24/22 of Staff #6's record revealed:<br>-Hired 12/21/21; | V 512 | | |

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| V 512 | Continued From page 109<br>-Employed as Residential Assistant;<br>-Trained in North Carolina Interventions (alternatives to restrictive intervention, seclusion, physical restraint, and isolation time-out) on 1/1/22.<br><br>Review on 2/14/22 of Licensee-Qualified Professional #2's (L-QP#2) record revealed:<br>-Hired 2/5/19;<br>-Signed job description dated 1/27/19 revealed: "...provide and/or assure completion of required training for residential assistant employees ..."<br><br>Review on 12/2/21 and 2/24/22 of Client #3's record revealed:<br>-Admitted 10/8/21;<br>-Diagnosed with Post-Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, and Disruptive Mood Dysregulation Disorder;<br>-17 years old;<br>-Height 5'11" and weight 241 pounds;<br>-History of fighting with peers and hit a peer's head into cement during a fight at a former placement.<br><br>Review on 12/29/21 and 2/14/22 of Client #4's record revealed:<br>-Admitted 12/3/21;<br>-Diagnosed with Post-Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, Generalized Anxiety Disorder, and Bipolar Disorder;<br>-14 years old;<br>-History of assault and verbal aggression through bullying.<br><br>Review on 2/22/22 of the law enforcement report dated 1/4/22 at 6:21pm revealed:<br>-" ...Assault between two clients, woman screaming let go of her hair, several people | V 512 | | |

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| V 512 | Continued From page 110 | V 512 | | |

yelling in the background, female yelling she can't breathe ...";

Review on 2/18/22 of Client #4's hospital documents from 1/4/22 provided by the Department of Social Services Legal Guardian (DSS LG) revealed:
-Client #4 was 5'2" and weighed 195 pounds;
-Reason for the visit was "initial trauma survey for injury;"
-Testing included CT (computerized tomography) of cervical spine, CT of facial bones, CT of head, X-ray of chest, and X-ray of pelvis.

Division of Health Service Regulation (DHSR) staff requested any additional incident reports from the L-QP#2 on 2/14/22. Copies of the facility's Level II incident reports were provided for Clients #3 and #4 each dated 1/4/22 regarding an assault. The provider comments on the incident reports revealed the provider would ensure increased supervision in order to keep Clients #3 and #4 separated for safety precautions.

Attempted review and interview on 2/24/22 with the L-QP#2 revealed L-QP#2 did not have copies of Client #4's hospital medical records from 1/4/22 but would contact the hospital to get the medical records. Later that afternoon, L-QP#2 revealed she contacted the hospital for the medical records but could not obtain them as she was not Client #4's legal guardian.

Attempted review and interview on 2/25/22 with Client #4's DSS LG revealed she did not have copies of Client #4's entire report from Client #4's hospital visit on 1/4/22. The DSS LG revealed she did not have the full report and only had the page which identified Client #4's height, weight, reason for visit, and tests performed. There were

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| V 512 | Continued From page 111 | V 512 | | |

no medical records available for review which contained the results of the testing or discharge recommendations.

Attempts on 2/25/22 to gain access to Client #4's hospital medical records were unsuccessful. Hospital staff revealed medical records release needed to be completed by a patient or legal guardian and there was no staff at the hospital to provide the records.

Interview on 2/22/22 with Client #1 revealed:
-Client #3 assaulted Client #2 a few weeks before Client #3 assaulted Client #4 on 1/4/22;
-The assault on Client #2 was not as bad as the assault on Client #4;
-Client #4 instigated the fight with Client #3 by saying Client #3 smelled and needed a shower;
-Client #3 jumped on Client #4;
-Staff #4 and #6 were working but they did not break up the fight or help;
-Staff #4 called law enforcement because Client #4 was injured;
-Client #4 was taken to the hospital in an ambulance;
-Client #4 returned to the facility but there was never an increase in staffing as a result of the assault.

Interview on 2/22/22 with Client #2 revealed:
-Was in a physical fight with Client #3 in November, 2021 which required law enforcement to come to the facility to break up the fight;
-Clients #3 and #4 were in a physical fight during which Client #4 was injured and was taken to the hospital;
-Staff (Staff #4 and #6) did nothing to break up the fight between Clients #3 and #4.

Interview on 12/1/21 with Client #3 revealed:

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| V 512 | Continued From page 112<br>-Had a fight with Client #2 a few weeks ago and law enforcement came to the facility to break up the fight.<br><br>Interview on 2/22/22 with Client #4 revealed:<br>-Was in a physical fight with Client #3 in early January, 2022;<br>-Client #3 had not showered, had her period, and smelled;<br>-Client #4 made comments about Client #3's hygiene;<br>-Was beaten up by Client #3;<br>-Staff #4 and #6 were working;<br>-Staff #4 and #6 did nothing but verbally tell Client #3 to stop the assault and get off Client #4;<br>-Client #4 was bleeding from the nose and in "a lot of physical pain;"<br>-Client #4 went to the hospital in an ambulance;<br>-Client #4's face was bleeding and she was placed in a neck brace by ambulance personnel;<br>-Hospital staff completed x-rays and other tests on Client #4;<br>-Client #4 returned to the facility but there was no change to staffing patterns after the assault and frequently experienced only one staff at the facility;<br>-"I got my a*s beat."<br><br>Interview on 2/18/22 with Client #4's DSS LG revealed:<br>-Client #4 had and altercation with Client #3 on 1/4/22;<br>-The DSS LG called Client #4 on 1/5/22 and Client #4 stated: "I got the s**t beat out of me;"<br>-Client #4 reported she told Client #3 that she smelled and had poor personal hygiene;<br>-Client #3 assaulted Client #4;<br>-Client #4 reported Client #3 sat on her, beat her, and spat at her;<br>-Client #4 reported being injured with "a sprained | V 512 | | |

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| V 512 | Continued From page 113 | V 512 | | |

neck, bloody nose, bruising;"
-DSS LG spoke with Staff #4 who told the DSS LG that Client #3 had her hands around Client #4's neck and tried to choke Client #4;
-Staff #4 told the DSS LG the assault was bad, but it was out of her hands and she needed to communicate with the L-QP#2;
-Staff #4 informed the DSS LG she was not trained to break up a fight, so she called law enforcement;
-DSS LG did not receive notification by facility staff, Qualified Professional #1, or L-QP#2 regarding the assault.

Interview on 2/24/22 with Staff #1 revealed:
-Did not know the extent of injury to Client #4 after she was assaulted by Client #3 on 1/4/22;
-Client #4 suffered a bloody nose and was taken to the hospital in an ambulance;
-Client #4 was not discharged from the hospital with a neck brace, splint, or other device;
-Did not know the tests performed on Client #4 as she was not present at the hospital during treatment and did not have the hospital medical records.

Attempted interviews with Staff #4 were unsuccessful. Three separate telephone attempts to reach Staff #4 on 2/23/22 and 2/24/22 resulted in a telephone recording indicating the party was temporarily unavailable with the directive to try the call again later. A text message was sent on 2/23/22 at approximately 6:45pm requesting a telephone call back, but no return telephone call was received.

Interview on 2/22/22 with Staff #5 revealed:
-Called the police for a welfare check at the facility after learning of the assault on 1/4/22, as she feared for the safety of the clients at the

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| V 512 | Continued From page 114<br>facility based upon the manner in which the facility was operated.<br><br>Attempted interview on 2/24/22 with Staff #6 was unsuccessful. A telephone message was left requesting a return call, but no return telephone call was received. A prior attempt had been made on 2/23/22 to the first number the L-QP#2 had provided, but the number had been an incorrect number.<br><br>Interviews on 2/14/22, 2/24/22, and 3/2/22 with the L-QP#2 revealed:<br>-Did not know the extent of the incident between Clients #3 and #4 or the extent of injury to Client #4 on 1/4/22;<br>-Staff #1 should know the details of the incident between Clients #3 and #4 and the extent of injury to Client #4 on 1/4/22;<br>-Did not have hospital medical records for Client #4 as a result of the 1/4/22 assault;<br>-Could not obtain hospital medical records for Client #4 as she was not the legal guardian;<br>-Acknowledged Staff #4 was not trained in alternatives to restrictive intervention or seclusion, physical restraint, and isolation time-out but should have been prior to providing services to clients;<br>-Staff #4 separated from employment on 1/25/22 during the DHSR survey;<br>-Staff #6 separated from employment on 2/21/22 during the DHSR survey;<br>-When asked if there was additional information to present or comments to make during the survey exit meeting on 3/2/22, no additional information was provided by L-QP #2.<br><br>Review on 3/2/22 of the Plan of Protection written by the L-QP#2 dated 3/2/22 revealed:<br>"What immediate action will the facility take to | V 512 | | |

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| V 512 | Continued From page 115<br>ensure the safety of the consumers in your care? Describe your plans to make sure the above happens.<br>V536: All staff will be trained in NCI (North Carolina Interventions) Preventive and Restrictive interventions upon hire. [Staff #3] and [Staff #1] are trained instructors. This will ensure that staff always have the availability to get trained and retrained if necessary. This issue will be rectified no later than 3/5/22. Staff have a training scheduled for 3/5/22.<br>V537: Staff are expected to intervene when there is an incident. When consumers are becoming physically aggressive, staff should utqize their NCI training. Failure to do so will result in immediate termination.<br>V512: Staff are expected to protect clients from harm, abuse, and neglect. Failure to do so will result in immediate termination. Director (L-QP#2) will review all incident reports and contact the appropriate contact (DSS, DHSR, etc.) if it is determined that any form of harm, abue, or neglect occurred."<br><br>Client #3 was 17 years old and diagnosed with Post-Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, and Disruptive Mood Dysregulation Disorder. She had a history of assaulting peers in current and former placements requiring intervention by law enforcement. Client #3 banged a peer's head against cement during an assault at a former placement. Client #4 was 14 years old and diagnosed with Post-Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, Generalized Anxiety Disorder, and Bipolar Disorder. Client #4 had a history of assault and verbal aggression through bullying. Client #4 instigated an argument with Client #3 on 1/4/22. Client #3 assaulted Client #4 by sitting on her, | V 512 | | |

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| V 512 | Continued From page 116<br>beating her, and spitting at her. Law enforcement was called to intervene between Clients #3 and #4. Client #4 required medical attention and diagnostic testing as a result of the assault. The extent of Client #4's injuries could not be determined due to the lack of medical records maintained by facility staff. Staff #6 had been trained in alternatives to restrictive intervention and restraint but did not intervene to separate and protect the clients. Staff #4 had not been trained in alternatives to restrictive intervention and seclusion, physical restraint, and isolation time-out. The Licensee-Qualified Professional #2 did not ensure Staff #4 had the necessary training to meet the requirements of the position held. This deficiency constitutes a Type A1 rule violation for serious harm and neglect. An administrative penalty of $2,000.00 is imposed. | V 512 | | |
| V 536 | 27E .0107 Client Rights - Training on Alt to Rest. Int.<br><br>10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS<br>(a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions.<br>(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.<br>(c) Provider agencies shall establish training based on state competencies, monitor for internal | V 536 | | |

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| V 536 | Continued From page 117<br>compliance and demonstrate they acted on data gathered.<br>(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.<br>(e) Formal refresher training must be completed by each service provider periodically (minimum annually).<br>(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.<br>(g) Staff shall demonstrate competence in the following core areas:<br>(1) knowledge and understanding of the people being served;<br>(2) recognizing and interpreting human behavior;<br>(3) recognizing the effect of internal and external stressors that may affect people with disabilities;<br>(4) strategies for building positive relationships with persons with disabilities;<br>(5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;<br>(6) recognizing the importance of and assisting in the person's involvement in making decisions about their life;<br>(7) skills in assessing individual risk for escalating behavior;<br>(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and<br>(9) positive behavioral supports (providing means for people with disabilities to choose | V 536 | | |

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| V 536 | Continued From page 118<br>activities which directly oppose or replace behaviors which are unsafe).<br>(h) Service providers shall maintain documentation of initial and refresher training for at least three years.<br>(1) Documentation shall include:<br>(A) who participated in the training and the outcomes (pass/fail);<br>(B) when and where they attended; and<br>(C) instructor's name;<br>(2) The Division of MH/DD/SAS may review/request this documentation at any time.<br>(i) Instructor Qualifications and Training Requirements:<br>(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.<br>(2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.<br>(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.<br>(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.<br>(5) Acceptable instructor training programs shall include but are not limited to presentation of:<br>(A) understanding the adult learner;<br>(B) methods for teaching content of the course;<br>(C) methods for evaluating trainee performance; and<br>(D) documentation procedures. | V 536 | | |

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| V 536 | Continued From page 119<br>(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.<br>(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.<br>(8) Trainers shall complete a refresher instructor training at least every two years.<br>(j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.<br>(1) Documentation shall include:<br>(A) who participated in the training and the outcomes (pass/fail);<br>(B) when and where attended; and<br>(C) instructor's name.<br>(2) The Division of MH/DD/SAS may request and review this documentation any time.<br>(k) Qualifications of Coaches:<br>(1) Coaches shall meet all preparation requirements as a trainer.<br>(2) Coaches shall teach at least three times the course which is being coached.<br>(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.<br>(l) Documentation shall be the same preparation as for trainers.<br><br>This Rule is not met as evidenced by: | V 536 | | |

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| V 536 | Continued From page 120<br><br>Based on interview and record review, the facility failed to ensure staff were trained in alternatives to restrictive intervention affecting 2 of 11 audited staff (Staff #2 and #4). The findings are:<br><br>Review on 2/23/22 of Staff #2's record revealed:<br>-Hired 2/14/22;<br>-Employed as Residential Assistant;<br>-No documentation of training in alternatives in restrictive intervention.<br><br>Review on 2/24/22 of Staff #4's record revealed:<br>-Hired 12/24/21;<br>-Employed as Residential Assistant;<br>-No documentation of training in alternatives to restrictive intervention.<br><br>Interview on 2/23/22 with Staff #2 revealed:<br>-Did not complete training in North Carolina Interventions (seclusion, physical restraint, and isolation time-out), but was scheduled to complete the training on 3/5/22.<br><br>Attempted interviews with Staff #4 were unsuccessful. Three separate telephone attempts to reach Staff #4 on 2/23/22 and 2/24/22 resulted in a telephone recording indicating the party was temporarily unavailable with the directive to try the call again later. A text message was sent on 2/23/22 at approximately 6:45pm requesting a telephone call back, but no return telephone call was received.<br><br>Interviews on 2/24/22 and 3/2/22 with the Licensee-Qualified Professional #2 (L-QP#2) revealed:<br>-Staff #4 separated from employment on 1/25/22 during the Division of Health Service Regulation survey;<br>-Did not know why Staff #2 and #4 were not | V 536 | | |

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| V 536 | Continued From page 121<br>trained in alternatives to restrictive intervention as there were two certified instructors employed by the agency making training readily available;<br>-Staff #2 was previously employed by another provider. Staff #2's training records were requested from the other provider, but no documents were received;<br>-Would ensure all staff were trained in alternatives to restrictive intervention prior to providing services;<br>-When asked if there was additional information to present or comments to make during the survey exit meeting on 3/2/22, no additional information was provided by L-QP #2. | V 536 | | |
| V 537 | 27E .0108 Client Rights - Training in Sec Rest & ITO<br><br>10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT<br>(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.<br>(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.<br>(c) A pre-requisite for taking this training is | V 537 | | |

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| V 537 | Continued From page 122<br>demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions.<br>(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.<br>(e) Formal refresher training must be completed by each service provider periodically (minimum annually).<br>(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.<br>(g) Acceptable training programs shall include, but are not limited to, presentation of:<br>(1) refresher information on alternatives to the use of restrictive interventions;<br>(2) guidelines on when to intervene (understanding imminent danger to self and others);<br>(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);<br>(4) strategies for the safe implementation of restrictive interventions;<br>(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;<br>(6) prohibited procedures;<br>(7) debriefing strategies, including their importance and purpose; and<br>(8) documentation methods/procedures. | V 537 | | |

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| V 537 | Continued From page 123<br>(h) Service providers shall maintain documentation of initial and refresher training for at least three years.<br>(1) Documentation shall include:<br>(A) who participated in the training and the outcomes (pass/fail);<br>(B) when and where they attended; and<br>(C) instructor's name.<br>(2) The Division of MH/DD/SAS may review/request this documentation at any time.<br>(i) Instructor Qualification and Training Requirements:<br>(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.<br>(2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out.<br>(3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.<br>(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.<br>(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.<br>(6) Acceptable instructor training programs shall include, but not be limited to, presentation of:<br>(A) understanding the adult learner;<br>(B) methods for teaching content of the course; | V 537 | | |

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| V 537 | Continued From page 124<br>(C) evaluation of trainee performance; and<br>(D) documentation procedures.<br>(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.<br>(8) Trainers shall be currently trained in CPR.<br>(9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach.<br>(10) Trainers shall teach a program on the use of restrictive interventions at least once annually.<br>(11) Trainers shall complete a refresher instructor training at least every two years.<br>(k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.<br>(1) Documentation shall include:<br>(A) who participated in the training and the outcome (pass/fail);<br>(B) when and where they attended; and<br>(C) instructor's name.<br>(2) The Division of MH/DD/SAS may review/request this documentation at any time.<br>(l) Qualifications of Coaches:<br>(1) Coaches shall meet all preparation requirements as a trainer.<br>(2) Coaches shall teach at least three times, the course which is being coached.<br>(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.<br>(m) Documentation shall be the same preparation as for trainers. | V 537 | | |

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| V 537 | Continued From page 125 | V 537 | | |

This Rule is not met as evidenced by:
Based on interview and record review, the facility failed to ensure staff were trained in seclusion, physical restraint, and isolation time-out affecting 2 of 11 audited staff (Staff #2 and #4). The findings are:

Review on 2/23/22 of Staff #2's record revealed:
-Hired 2/14/22;
-Employed as Residential Assistant;
-No documentation of training in seclusion, physical restraint, and isolation time out.

Review on 2/24/22 of Staff #4's record revealed:
-Hired 12/24/21;
-Employed as Residential Assistant;
-No documentation of training in seclusion, physical restraint, and isolation time out.

Interview on 2/23/22 with Staff #2 revealed:
-Did not complete training in North Carolina Interventions (seclusion, physical restraint, and isolation time-out), but was scheduled to complete the training on 3/5/22.

Attempted interviews with Staff #4 were unsuccessful. Three separate telephone attempts to reach Staff #4 on 2/23/22 and 2/24/22 resulted in a telephone recording indicating the party was temporarily unavailable with the directive to try the call again later. A text message was sent on 2/23/22 at approximately 6:45pm requesting a telephone call back, but no return telephone call was received.

Interviews on 2/24/22 and 3/2/22 with the

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| V 537 | Continued From page 126<br><br>Licensee-Qualified Professional #2 (L-QP#2) revealed:<br>-Staff #4 separated from employment on 1/25/22 during the Division of Health Service Regulation survey;<br>-Did not know why Staff #2 and #4 were not trained in seclusion, physical restraint, and isolation time out as there were two certified instructors employed by the agency making training readily available;<br>-Staff #2 was previously employed by another provider. Staff #2's training records were requested from the other provider, but no documents were received;<br>-Would ensure all staff were trained in alternatives to seclusion, physical restraint, and isolation time out prior to providing services;<br>-When asked if there was additional information to present or comments to make during the survey exit meeting on 3/2/22, no additional information was provided by L-QP #2. | V 537 | | |
| V 774 | 27G .0304(d)(7) Minimum Furnishings<br><br>10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT<br>(d) Indoor space requirements: Facilities licensed prior to October 1, 1988 shall satisfy the minimum square footage requirements in effect at that time. Unless otherwise provided in these Rules, residential facilities licensed after October 1, 1988 shall meet the following indoor space requirements:<br>(7) Minimum furnishings for client bedrooms shall include a separate bed, bedding, pillow, bedside table, and storage for personal belongings for each client. | V 774 | | |

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| V 774 | Continued From page 127 | V 774 | | |

This Rule is not met as evidenced by:
Based on interview, record review, and observation, the facility was not maintained with minimum furnishings affecting 2 of 2 clients (Clients #2 and #3). The findings are:

Observations on 12/1/21 at approximately 3:15pm and 2/21/22 at approximately 10:35am of the right rear bedroom of the facility revealed:
-The only furnishing in the room was a bed with linens.

Review on 12/2/21 and 2/24/22 of Client #2's record revealed
-Admitted 7/26/21;
-Diagnosed with Post-Traumatic Stress Disorder, Oppositional Defiant Disorder, Mood Disorder, Major Depressive Disorder, and Insomnia;
-17 years old.

Review on 12/2/21 of Client #3's record revealed:
-Admitted 10/8/21;
-Diagnosed with Post-Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, and Disruptive Mood Dysregulation Disorder;
-17 years old.

Interviews on 12/1/21, 2/21/22, and 3/2/22 with the Licensee-Qualified Professional #2 (L-QP#2) revealed:
-Would purchase additional furnishings for the bedroom;
-Client #3 was discharged on 2/11/22 on her 18th birthday and returned home to her mother;
-Client #2 moved into Client #3's bedroom when Client #3 discharged;
-Had ordered and received additional furnishings

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| V 774 | Continued From page 128<br>for the bedroom but needed to assemble the items;<br>-When asked if there was additional information to present or comments to make during the survey exit meeting on 3/2/22, no additional information was provided by L-QP #2.<br><br>This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation. | V 774 | | |