STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601487	A. BUILDING: _____ B. WING _____	03/15/2022

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WILLIAMSON COTTAGE-THOMPSON CHILD AND FAM	6700 SAINT PETERS LANE MATTHEWS, NC 28105

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 3-15-22. The complaints were unsubstantiated (#NC00185896, #NC00184654, #NC00186869). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1800 Intensive Residential Treatment for Children or Adolescents. This facility is licensed for nine and currently has a census of four. The survey sample consisted of two current clients and two former clients.	V 000		
V 301	27G .1801 Intensive Res. Tx. Child/Adol - Scope 10A NCAC 27G .1801 SCOPE (a) An intensive residential treatment facility is one that is a 24-hour residential facility that provides a structured living environment within a system of care approach for children or adolescents whose needs require more intensive treatment and supervision than would be available in a residential treatment staff secure facility. (b) It shall not be the primary residence of an individual who is not a client of the facility. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, severe emotional and behavioral disorders or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for acute inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to an intensive integrated treatment setting; and	V 301	V301- **CORRECTION**: 1. Program Supervisors will review expectations regarding client supervision, engagement, and TCI/De-escalation techniques during shifts with Residential Care Specialists (RCS). 2. VP of Residential to meet with Recreation Therapist to provide more therapeutic activities for RCS to engage clients throughout the shifts. **PREVENTION:** 1. Program Supervisors will provide observations of RCS that include camera reviews of shifts once a week. 2. Program Supervisors will provide individualized coaching as needed of RCS as needed.	by 4/27/22 by 4/27/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Hannah Dunham LCSW, Chief Performance & Quality Officer 4/6/2022

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V 301	Continued From page 1 (2) treatment in a locked setting. (e) Services shall be designed to: (1) assist in the development of symptom and behavior management skills; (2) include intensive, frequent and pre-planned crisis management; (3) provide containment and safety from potentially harmful or destructive behaviors; (4) promote involvement in regular productive activity, such as school or work; and (5) support the child or adolescent in gaining the skills needed for reintegration into community living. (f) The intensive residential treatment facility shall coordinate with other individuals and agencies within the child or adolescent's system of care. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to provide intensive supervision to meet the needs of the clients and ensure safety from harmful and destructive behaviors. The findings are: Cross referenced 10A NCAC 27G .1804 Minimum Staffing Requirements (V304): Based on interviews and record reviews, the facility failed to meet the minimum staffing requirements. Interview on 3-1-22 with the Vice President of Residential Services revealed: -The schedule did not always accurately reflect how many staff were working.	V 301	**MONITORING:** 1. VP of Residential will utilize weekly supervisions of Program Leaders to ensure compliance with prevention plan. 2. PQI will review incident reports monthly with Program Leaders. 3. PQI & VP of Residential will conduct random camera reviews monthly.	Ongoing

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-The Program Supervisor would sometimes work, but not add their name to the schedule.
-The staff have all received training to help them respond to issues in a more timely manner.
-He had been working to hire more staff.

Review on 3-2-22 of the Plan of Protection dated 3-1-22 and signed by the Program Director revealed:

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

"-Daily checking of scheduling to ensure ratios are consistently in place.
-Immediate communication with Program Supervisor when they are call outs (3-1-22)
-Emailed staff supervisors 2-25-22 directing that all staff be required to remain on shift until following shift is in ratio.
-emailed staff 2-25-22 to ensure plan is submitted 3/2 detailing increased responsiveness from staff during crisis."

Describe your plans to make sure the above happens.

"[Program Director], program director will ensure all aforementioned actions/plans are implemented as required. Should any issue arise, will consult with VP [Vice President of Residential Services]."

Clients diagnoses that included Oppositional Defiant Disorder, Anxiety Disorders, Disruptive Mood Dysregulation Disorder, and Bipolar II disorder. Client had dangerous behaviors, including physical aggression, running away, self harming behaviors, suicide ideation, and property destruction. The revied schedule from November

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V 301	Continued From page 3 2021 through January 2022 there were twelve times on third shift, two times on first shift and twenty three times on second shift when only two staff were scheduled for all or part of the shift during the reviewed period. During this time there were ten documented incidents, with issues including clients fighting each other, clients attacking peers and staff, and property destruction. The staff were unable to provide safety and crisis management for potentially harmful behaviors. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients. If the violation is not corrected within 45 days, an administrative penalty of 200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day. -	V 301		
V 304	27G .1804 Intensive Res. Tx. Child/Adol - Min staffing 10A NCAC 27G .1804 MINIMUM STAFFING REQUIREMENTS (a) A Qualified Professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) If children or adolescents are cared for in separate units/buildings, the minimum staffing numbers shall apply to each unit/building. (c) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) three direct care staff shall be present for up to six children or adolescents;	V 304	V 304- **CORRECTION:** 1. VP of Residential will re-train Program Director and Program Supervisors of minimum staffing requirements. 2. Program Supervisor will ensure that minimum ratio requirements are met on all shift and accurately represent the staff scheduled. 3. The residential attendance policy and mandatory and voluntary overtime and scheduling operating guideline will be updated by the VP of Residential. 4. RCS will be trained by Program Supervisors on the updated operational guideline changes.	by 4/27/22

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V 304	Continued From page 4 (2) four direct care staff shall be present for seven, eight or nine children or adolescents; and (3) five direct care staff shall be present for 10, 11 or 12 children or adolescents. (d) During child or adolescent sleep hours three direct care staff shall be present of which two shall be awake and the third may be asleep. (e) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(d) of this Rule, more direct care staff may be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to meet the minimum staffing requirements. The findings are: Review on 1-31-22 of Former Client #1's (FC#1) record revealed: -Admitted 12-15-21, discharged 1-25-22. -10 years old. -Diagnoses include; Post Traumatic Stress Disorder (PTSD), Attention-Deficit/Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), and Reactive Attachment Disorder (RAD). -Person Centered Plan dated 12-16-21 revealed; "three disrupted placements since October 2021...emotional outbursts, difficulty following directions, engagements in power struggles, difficulty respecting personal boundries, verbal aggression, physical aggression, and unsafe behavior such as running away and banging her head against a tree...goals	V 304	**PREVENTION:** 1. VP of Residential will continue focus on hiring additional PRN and full-time RCS to meet minimum staffing coverage of programs. 2. Program Supervisors will work in ratio to provide minimum staffing coverage if needed. 3. Program Supervisors will submit staffing schedules to Program Director/VP of Residential for review of compliance with staffing ratio weekly. 4. If RCS and Supervisors are not compliant with the updated guidelines then the Program Director/VP of Residential will follow Thompson's progressive discipline policy. **MONITORING:** 1. VP of Residential will utilize weekly supervisions of Program Leaders to ensure compliance with prevention plan. 2. PQI & VP of Residential will conduct random camera reviews monthly. 3. PQI conducts internal investigations as needed and internal reviews annually.	Ongoing Ongoing Ongoing

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included, increase emotional regulation skills and utilize them 4 out of 7 days...decrease engagement in risky unsafe behavior...crisis plan included; triggers; worries she can't talk to her brother... when she feels peers are lying... when asked multiple times to complete non-preferred task... being bullied. Ways to help; listening to music, stress ball, essential oils, hugs, playing outside, playing games, going for walk, separating from peers she is experiencing conflict with."

-Assessment addendum dated 10-19-21 revealed; "inability to form healthy relationships with others due to the number of placements that she has been in...brought in the ED (Emergency Department) due to the aggression shown in the house...continued aggression, non-compliance, and limitations with building and maintain relationships...easily triggered when asked to do something she does not want to...inability to utilize coping skills to calm herself...needs constant support by actively engaged adults..."

Review on 2-11-22 of Former Client #2's (FC#2) record revealed:

-Admitted 12-13-21, discharged 1-25-22.

-12 years old.

-Diagnoses of ADHD, Anxiety Disorder, Reaction to severe stress.

-Assessment dated 11-11-21 revealed; "...has experienced numerous adverse experiences of early childhood which places her at greater risk for social emotional problems. She is a traumatized child who is in a constant state of high alert and tends to quickly become hyper aroused in fight or flight mode. When this occurs, she acts impulsively without thought of her statements or actions. She has been socially isolated and quickly becomes emotionally overwhelmed and highly anxious."

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V 304	Continued From page 6 -Person Centered Plan dated 12-14-21 revealed; "prefers he/him pronouns..has a history of being disrespectful to others and using profanity around other children. At school [FC#2] has made inappropriate comments, yelled in class and been physically aggressive to his peers..There have been a few instances where [FC#2] has picked the lock of the therapist's office to enter without permission or has stood outside of the therapist's door to listen in on meetings and sessions with other clients..." Goals include; "increase his emotional regulation skills and utilize them 4 out of 7 days of the week to assist with managing emotions appropriately as evidenced by the identification of triggers, appropriate expression of emotions, refrain from engaging in physical aggression towards peers and staff 4 out of 7 days of the week to decrease interpersonal conflict and ensure safety." Crisis Plan; triggers include not having his wants and needs met immediately and when he feels that his peers are being loud or not respecting his personal space and private conversations, being misgendered, being called by his birth name, discussing his grandfather and the trauma, and the movie Home Alone (client reports that his grandfather used to make him watch the movie over and over when he was younger and would hit him when he tried to get up to do something else). Give clear instructions so he doesn't feel like he is being lied to. Review on 1-31-22 of Client #3's record revealed: -Admitted 11-3-21. -15 years old. -Diagnoses include: Disruptive Mood Dysregulation Disorder (DMDD), and Bipolar II Disorder. -Person Centered Plan dated 11-4-21 revealed; verbal aggression, physical aggression,	V 304		

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and property damage...significant history of self harming in the form of cutting, homicidal ideation as well as suicide ideation and attempts...attempted to overdose in December 2020 and that she attempted to kill her mother by putting Benadryl in her coffee...hospitalized 9 times since 2016...update 12-30-21 due to the continued increase in the frequency and intensity's of [Client #3]'s behavioral challenges the team agreed to change her clinical recommendation to Level IV PRTF (Psychiatric Residential Treatment Facility)...goals include increase her emotional regulation skills...decrease engagement in unsafe, risky behaviors."

-Comprehensive Clinical Assessment Addendum dated 12-13-21 revealed: "recently [Client #3] has been struggling with verbal aggression towards peers and staff when she is frustrated or asked to do a non-preferred task....will make threats to become physically aggressive...reported that she sees people that others do not see and these people 'take over' her and make her engage in aggression towards others..."

Review on 2-4-22 of Client #4's record revealed:

-Admitted 12-7-21.

-13 years old.

-Diagnoses include ADHD, PTSD, ODD.

-Person Centered Plan updated 12-7-21 revealed:" identifies as non-binary, and his preferred pronouns are he/him....experiences challenges with peer conflict, using profanity, self-injury, fighting at school when being bullied by peers, lack of impulse control, boundary issues, property destruction and a history of suicidal ideation...update 1-5-22; continues to experience conflict with peers and difficulty regulating his emotions in appropriate ways

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especially without additional support from the therapist or staff. Goals include; decrease his engagement in risky, unsafe, and harmful behavior such as leaving the premise without supervision, engaging in physical altercations, destroying property and self-injurious behavior to 3 out of 7 days of the week as evidenced by staff and self-report, will increase his emotional regulation skills and utilize them 4 out of 7 days of the week to assist with managing emotions as evidenced by the identification of triggers, appropriate expression of emotions, participation in group and individual therapy and the utilization of effective coping skills..."

-Comprehensive Clinical Assessment dated 12-14-21 revealed: "There have been instances of peer conflict, difficulty following directions and respecting personal boundaries, verbal aggression, physical aggression, property destruction and thoughts of wanting to self-harm while [Client #4] has been at the program...has been able to use his coping skills independently during early signs of crisis. When he is unable to utilize coping skills independently, he is able to return to baseline with additional assistance from preferred staff and natural supports."

Review on 2-18-22 of Staff Schedule for November- December 2021 and January 2022 revealed:

-First shift was 7:00am to 3:00pm, second shift was 3:00pm to 11:00pm, third shift was 11:00pm to 7:00am.

-According to the schedule: there were twelve times on third shift, two times on first shift and twenty three times on second shift when only two staff were scheduled for all or part of the shift during the reviewed period.

Review on 2-18-22 of the facility's incident reports

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from November 2021 through January 2022 during the time when only two staff where scheduled revealed:

-11-22-21, 12:30pm; "After returning back from a walk outside, [Former Client #5] asked about using staff laptops because client laptops weren't currently working. Staff told her no. [Former Client #5] got upset and asked to speak with supervisor [Supervisor]. Staff advised that she could send a text but would not call because she was in ratio. [Former Client #5] got upset and said she was going to throw the bowl she had at the wall and told the other staff to move out of the way. She threw a glass bowl at the wall, poured the jug of milk on the floor and the cereal box. She started picking up pieces of glass from the ground and began throwing it trying to hit staff. A piece of glass did hit staff and cut them. She was yelling and cussing at staff. Threatening to hit them and cut them."

-12-12-21, 13:05 (3:05); "[Client #3] took an item from the closet in the laundry room, without permission and stuck it in her shirt. Staff... asked Client what did she take. Client kept walking out of the kitchen away from Staff and went into her bedroom with the item and closed the door. Client later opened her bedroom door and stood in the doorway. Client then asked Staff 'What the f**k are you looking at B***h, I'll punch you in your f*****g face'. Client stood there for a moment and was overheard telling her peer... 'I have too much energy, if they don't let me go the f**k outside there's going to be a problem'. Client then turned around and went in her room."

-12-17-21, 18:00 (6:00pm); "The client had a phone call with a family member. Following the phone call the client went immediately into their bedroom and through a chair. Staff went to check on the client and the client had started to return to baseline. The client asked for some time and

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space. The client was able to return to baseline (client's normal behavior) and express to staff that they were frustrated with their grandpa because they felt like their grandfather was lying to them. The client maintained at baseline the rest of the night."

-1-1-22, 18:00 (6:00pm); "The client asked staff if they could go on a walk and during that time staff was unable to go on a walk. The client got upset and began to curse and use inappropriate language with staff. Staff attempted to redirect the client and encouraged the client to use appropriate language. The client continued to ignore staff and then went and broke into an empty bedroom. The client initially refused to come out of the bathroom that was in that bedroom. The client eventually came out of the bedroom and went outside with a staff to take some time to return to baseline. The client did return to baseline and had no further behaviors during the shift."

-1-6-22, 20:30 (8:30pm); "The peer then chased the client down the hallway and the client (FC#1) was spraying the peer with disinfectant spray. The peer then began to hit and kick the client while she was on the ground. Code safe was then called however none of the clients wanted to go to their room. The client then began making comments towards one of her peers that was in the room across from her. The peer attempted to close her door in an effort to ignore the client, however the client began writing notes and sliding them under the peer's door. The peer than came out of her room and began physically attacking the client, causing the client to fall to the floor and hit her head on the door. The client's other peers also came down the hallway and began hitting and kicking her before staff was able to verbally separate the all the clients."

-1-6-22 20:30 (8:30pm)-"The client (Former

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Client #6) got into a verbal altercation with one of her peers. The client attempted to ignore her peer by going into her room and closing her door, however her peer slide notes under her door. Due to the peer continuing to make comments towards her the client came out of her room and became physically aggressive towards the peer by hitting and kicking her. The client pushed the peer to the ground causing her to hit her head on the door. Once the peer was on the ground the client eventually walked away laughing down the hallway when staff came to separate them."

-1-6-22, 20:30 (8:30pm); "The client (FC#2) chased her peer down the hallway as her peer was spraying her with disinfectant spray. Once down the hallway the client then began to hit and kick her peer till she fell to the ground. Once on the ground the client continued to kick her peer before staff was able to verbally remove the client."

-1-6-22, 20:30 (8:30pm); "The client (Client #3) got into a verbal altercation with one of her peers (FC#1) and hit one of her peers with a candy cane. The peer went down the hallway spraying another peer with disinfectant spray. The client followed her peers and then pulled a client to the ground by her hair and took the spray from her, then gave it to staff."

-1-14-22, 19:00 (7:00pm) FC#1; "Client [FC#1] got upset that another peer took her chair and went into a crisis. [FC#1] went into a vacant room and locked herself in there while also barricading herself with furniture. Client was screaming and using profanity."

-1-15-22, 10:03am; "[Client #3] was antagonizing and threathening her peer and was asked to stop by staff [Staff #5]. [Client #3] told peer [FC#1] 'shut the f**k up before I stomp your head in again.' [Staff #5] asked her to stop and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 304	Continued From page 12 [Client #3] began using profanity towards staff [Staff #5]. This writer asked [Client #3] to watch her language and [Client #3] became upset and threw a sanitizer bottle at [Staff #5]'s head. [Client #3] then jumped up and charged at [Staff #5]. This writer jumped in between the two and 2 hand guided client [Client #3] into the kitchen." -1-21-22, 15:58-20:15 (3:58-8:15pm); "... Unprovoked the client (FC#2) walked back into the dining room and grabbed his younger peer by the hair and dragged her to the ground and towards the door. The client let go when redirected by staff. Staff asked the client to go to the his room and he refused. The client sat in the common room and returned to baseline. However a short time after the client went down a hallway that he doesn't sleep on and was instigating and antagonizing one of his younger peers. Staff instructed the client to return to the common room or his room. The client refused to follow instructions and continued to instigate his younger peer. The staff was able to redirect the younger peer out of the hallway and she was walking towards the dining room, the client tripped his younger peer. The younger peer kept walking towards the dining room and the client went after the peer, physically attacking her. Staff was able to immediately separate the two of the clients. And the client went to his room. Staff attempted to process with the client about why he was attacking his peer and he didn't say anything. Staff then took the client outside to return to baseline and he did. The client remained at baseline until after hygiene was completed, and for an unknown reason the client became escalated again and went into his bedroom and began engaging in property destruction by throwing and breaking things. After 5 minutes the client came out of his room and went to the entry	V 304		

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way and began kicking the front door in an effort to kick it in. Staff attempted to talk to the client but he told them to go away. Staff gave the client some space and time to return to baseline on his own."

-1-23-22, 12:20pm; "[FC#1] was out in the foyer already in a crisis and was dealing with staff. [FC#2] came out into the foyer making comments to peer [FC#1] 'I'm going to drag you by your hair' Staff redirected client to exit foyer and allow staff to handle said peer. Peer was hiding behind the door when client [FC#2] reached in between 2 staff and tried to pull peer [FC#1] hair. He was unsuccessful at pulling peers hair but did admit to kicking her. Staff sent client to his room to de-escalate. Client complied and no further issues ensued."

-1-29-22, 22:00 (10:00pm); "When the reporter arrived on shift the resident (Client #3) was sitting behind the desk with the remote in her hand watching YouTube. Staff redirected the resident multiple times and the resident ignored staff and became defensive with an attitude. The resident ignored the staff and never complied."

-According to the reviewed schedule, three staff had been scheduled to work on 1-6-22, but review of the camera footage on 2-4-22 showed only two staff working.

Interview on 2-1-22 and 2-11-22 with FC#1 revealed:

-During the incident on 1-6-22 the staff (Staff #1 and Staff #2) "was down the hall sitting at the desk."

-FC#2 liked to go into the facility foyer and staff would let her go there to calm down.

-She could not remember how many staff worked per shift.

Interview on 2-22-22 with FC#2 revealed:

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-There were usually 3 staff per shift, sometimes 2 on third shift. He then later said that it was "frequently" only two staff because "so many people had quit."

-1-6-22 incident: "My friend [Client #4] was telling staff (Staff #1 and Staff #2) 'they are fighting, they are fighting,' and staff said [FC#2] can handle it. So [Client #4] went took the spray and then I started kicking her and staff came and pulled me off an blamed me for it. One staff was there from what I can remember."

-He did like to go into the foyer, but staff would check on him to make sure he was OK.

-He had pulled FC#1's hair, but, "it happened so quickly, there was nothing staff could do."

-The Supervisor had pulled another staff from a different cottage, so he thought that there were three people working the shift when he pulled FC#1's hair.

Interview on 1-31-22 and 2-15-22 with Client #3 revealed:

-There were two staff working that day (1-31-22).

-There are usually two staff but, "sometimes we have three."

-She can't remember anyone pulling FC#1's hair.

-She has seen fights when there were only two staff, but can't remember when.

Interview on 1-31-22 with Client #4 revealed:

-Staff treated him very well.

-He had seen one restraint when FC#2 was kicking FC#1 but couldn't remember when that was.

-There were two or three staff working each shift daily.

Interview on 1-31-22 with Client #6 revealed:

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V 304	Continued From page 15 -She had been at the facility for one week. -There were two staff working at the time (1-31-22), but a third one was supposed to be coming in to work. -She hasn't seen any fights, but the other girls in the cottage, "like to fight." Interview on 1-31-22 with Client #7 revealed: -There were usually three-four staff working. There were currently four staff working at the cottage now (1-31-22). Interview on 2-3-22 with Staff #1 revealed: -"On second (shift) normally two (staff) but it is three now (2-3-22). First shift has four-five people, third shift has four-five people as well." -She remembers the incident when FC#2 pulled FC#1's hair and she thought that there had been three staff that day. She immediately told FC#2 to release FC#1, and she had. -There is normally two staff on second shift. Interview on 1-31-22 with Staff #2 revealed: -"Right now we have 4 girls so it is two (Staff)." -She has seen "quite a few" fights. -The only client that she had seen get hurt was FC#1. -The last fight she witnessed they had three staff working with "five-six kids." Interview on 2-3-22 with Staff #3 revealed: -There were typically three staff, but he has seen two staff working. -On 1-15-22 there was an incident and they had just two staff working. -Client #3 tried to hit Staff #5. -There was an incident where all the clients "ganged up" on FC#1. He had not been working that shift.	V 304		

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V 304	Continued From page 16 -"All (clients) just hitting her (FC#1) and pulling hair. I think that was after Christmas." -"Ratio is supposed to be 1:2 so there can be a better outlook for then so we can watch them. It helps the kids get the attention that they need. I don't think anybody ever told me it was supposed to be 1:2 that is just what we experienced." Interview on 2-7-22 with Staff #4 revealed: -"My shift it is usually two-three (Staff). Yesterday I worked with one person it was [Staff #1]." -She didn't remember a spray bottle in the incident on 1-6-22. -FC#2 hit FC#1 on 1-6-22. -" I was sitting down they (the other clients) said that they were fighting. She (FC#1) was on the floor down the hall, by her bedroom. I don't remember her being down on the floor in the dayroom." Interview on 2-15-22 with the Registered Nurse revealed: -Staff ratio depends on how many clients they have. "Today there is four because we have seven clients. I have seen just two staff." Interview on 2-18-22 with the Therapist revealed: -Staffing "depends on the amount of individuals we have. I have been informed that it should be one staff to two clients." -The incident on 1-6-22 was on the weekend, so she hadn't been working that day. -"I do know it was two staff (working)." -She has been here since July and has seen, "let's guess, four-five" fights. -She knows that a client attacked a staff and there were only two staff working, but couldn't remember when that was.	V 304		

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V 304	Continued From page 17 Interview on 2-21-22 with the Therapist Supervisor revealed: -The therapist would be in ratio if a staff has to step out for a moment, but they are not scheduled to be in ratio. -She has seen two staff working a shift. Interview on 1-31-22 and 2-21-22 with the former Program Supervisor revealed: -"Our ratio is 1:2, one staff for two kids so if we have four kids it would be two staff." -Following the incident on 1-6-22 the two staff that were working had individual supervision due to their lack of response, and the entire cottage had also had a training. -They were having issues because of Covid. They could not get people to work. -"Yeah, a pretty significant amount of times (Two staff worked). Pretty consistently on second shift. There was some overlap from first and third." -She did make the schedule. Interview on 2-21-22 with the Program Director revealed: -The Program Supervisor makes the schedule. -"We have somebody that will count as the third if they are TCI (Therapeutic Crisis Intervention) trained. That is [Program Supervisor] or the nursing staff they are all people that could be on the floor if need be." -"The Nurse is on part of second shift, it depends on the day." This deficiency is cross referenced into 10A NCAC 27G .1801 Scope (V301) for a Type B rule violation and must be corrected within 45 days.	V 304		

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V 537	Continued From page 18	V 537	**CORRECTION:** 1. Staff #6 is no longer with the agency.	by 5/13/22
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to	V 537	2. RCS staff will be re-trained by certified TCI instructor/Program Supervisors on TCI techniques with a focused on de-escalation strategies that will include role playing activities to measure competency when managing client behaviors. **PREVENTION:** 1. Will continue to provide TCI training at initial hire and refresher at least every six months which include demonstrations of competency of RCS staff. **MONITORING:** 1. Training is monitored by Program leaders through Relias LMS weekly for training compliance. 2. Program Supervisor will monitor training compliance in monthly supervisions with RCS staff. 3. PQI & VP of Residential will conduct random camera reviews monthly. PQI conducts internal investigations as needed and internal reviews annually.	Ongoing

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V 537	Continued From page 19 Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the	V 537		

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V 537	Continued From page 20 need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once	V 537		

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V 537	Continued From page 21 annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on interviews and record reviews one of four audited staff (Staff #6) failed to demonstrate competency when performing restrictive interventions. The findings are: Review on 3-10-22 of Staff #6's training record revealed: -CARE training 2-23-21, Client rights, 1-20-10, Therapeutic Crisis Intervention training 5-25-21.	V 537		

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Interview on 3-10-22 with Client #3 revealed:
-Things were "going good" and staff treated her well.
-There were no problem with any staff.
-Then stated she "doesn't get along" with Staff #6.
-"He gave me permission to make juice in the kitchen. He tried to snatch it from my hand and said I can't make it. I told him he just said I could. I walked over to get sugar. He tried to took the sugar. He tried I wouldn't let it go. He blocked the way to the door so I couldn't get out. I tried to walk out the dining room door he pushed me into the fried. He pushed me into the common room."
- She then said he wrapped his arms around her shoulders and walked her out, then stated that he pushed her out of the kitchen. wrapper her up, then says he pushed her shoulders
-Client #3 was very reluctant to talk about about the incident.
-She did say that she kicked Staff #6 because he was blocking the door to the kitchen.

Interview on 3-10-22 with Client #4 revealed:
-He doesn't like Staff #6 because "he won't give me my stuff."
-He did see Staff #6 push Client #3 out of the kitchen.

Interview on 3-10-22 with Client #6 revealed:
-She never saw him push anyone in the kitchen. "Other kids complain he is too strict. He has unfair treatment."

Interview on 3-10-22 with Client #7 revealed:
-She saw Staff #6 push Client #3 out of the kitchen.

Interview on 3-10-22 with Client #8 revealed:
-She saw Staff #6 push Client #3 out of the

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V 537	Continued From page 23 kitchen. Interview on 3-11-22 with Staff #7 revealed: -She had been working the day of the incident. -"He (Staff #6) was escorting her (Client #3) out and walked her to her room... he had his hands on her. If I'm not mistaken his hand was wrapped around her upper torso as someone coming behind you to give you a hug. His arms were double wrapped around her. He was walking her out, She was kicking and hitting him." -The clients "feed off each other. If one kid says this happened they will go along with it. They will try to protect each other. Especially if it is something against a staff there is no returning." Interview on 3-11-22 with Client #3's therapist revealed: -"She (Client #3) said that she was trying to get out and he (Staff #6) was trying stop her from getting out. Then she said she hurt her leg but didn't say what happened. She never said [Staff #6] pushed or grabbed her, she just said [Staff #6] tried to keep her from leaving and then said she hurt her leg. She has shown hostility toward [Staff #6]." Interview on 3-15-22 with Staff #6 revealed: -Client #3 had come into the kitchen with his permission to get dome juice. -Client #3 then went to another cabinet and got something that he could not see. -He did not know what Client #3 had, "that was when I grabbed her." -He was worried Client #3 might have grabbed something dangerous, such as a knife. -Client #3 then tried to walk out of the kitchen but he blocked the door. -He then walked her out with one hand on her	V 537		

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V 537	Continued From page 24 back area and and one hand wrapped around her wrist.	V 537		