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ALEXANDER TRANSITION HOUSE	6324 THERMAL ROAD CHARLOTTE, NC 28211

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 3/31/22. The complaint was substantiated(Intake #185898). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 6 beds and currently has a census of 6 clients. The survey sample consisted of audits of 6 current clients.	V 000		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have	V 109	Upon review of the supervision plans that were not completed there were a combination of issues that were assessed. The Transition House Program Manager is responsible for completion of annual supervision plans and monthly documentation for staff. Failures with the current process occurred as a result of the Program Manager not completing monthly supervision plans timely and errors within the HR/Payroll (E3) software. Annual supervision plans auto populate upon completion of onboarding and new hire training when credentials are entered into the system properly. The Program Manager completes the annual supervision plan and begin completion of the monthly documentation each month thereafter. Annual plans and monthly documentation are completed for all staff who are para professionals, associate professionals, and PRN staff who are not QP's. Identified were people and systematic issues as it related to staff competency and with our E3 software as it relates to supervision plans for all staff. In April of 2021, initial contact was made with E3 to address the supervision plan issues. It was determined that the E3 software implemented a new form for the annual supervision plans. As a result of the change it impacted criteria to assess each staffs needs	4/23/22

			and/or progress. Ongoing meetings (May 5 & May 13, 2021 occurred to address these errors with the E3 software developers. Several errors were identified, technical issues with our E3 system, entry errors, etc. In order to correct the areas of concern a meeting was held with the E3 system representative. On February 14, 2022 a meeting was held and review of the issues were addressed. On March 11, 2022, HR and the Performance Improvement Manager met with E3 to obtain follow up information regarding errors that presented within the system. As of April 21, 2022 E3 developers shared internal errors with the E3 system that requires manual review and deletion. Continuous collaboration with E3 remains until the system issues are resolved. In the interim ongoing monthly compliance has occurred to ensure monthly supervision plans are completed timely.	

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V 109	Continued From page 1 met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure 1 of 1 Former Qualified Professional(Former Program Manager/FPM) demonstrated knowledge, skills and abilities required by the population served. The findings are: Review on 3/18/22 and 3/21/22 of FPM's personnel record revealed: -hire date of 10/26/19; -assumed position of the Program Manager on 8/18/21; -termination date of 3/22/22; -documentation of completion of all required trainings in the record. Interview on 3/28/22 with the Vice President(VP) of Residential Services revealed: -the FPM was the Qualified Professional for the facility; -met with the FPM once a week for clinical	V 109		

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V 109		V 109		
	Continued From page 2 supervision regarding clients; -had a long talk with the FPM about clients' sexual histories and their need for close supervision; -informed the FPM to look at safety plans for clients and ensure staff were monitoring clients' proximity to each other; -also informed FPM to catch staff up to date on client issues; -talked with the FPM about what was his responsibility for the treatment plans; -told the FPM to have TL#1 assist with developing treatment plans. Refer to V111 and V112 regarding strategies to address client needs. Client #5 and client #6 had histories of sexualized behaviors and substance abuse but there were no strategies in place to address these behaviors. Client #5 and client #6 engaged in sexual behaviors and also used illicit substances while at the facility. The FPM was responsible for developing the strategies and treatment plans to address the issues for clients #5 and #6. Interview on 3/24/22 with the FPM revealed: -med(medication) orders "were all our responsibility;" -"falls on [local management entity/LME] to have the med orders when clients are admitted, [LME] arranges the placement;" -he no longer worked at the facility. Interview on 3/22/22 and 3/25/22 with the Executive Director revealed: -he was unaware there were no physician orders for the medications in the records; -"my nursing team did the training and they confirmed they had explained all that to the prior Program Manager(FPM) about having med			

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V 109		V 109		
	Continued From page 3 orders;" -he was unaware Team Leads knew nothing about getting med orders. Refer to V118 regarding medication administration. There were no physicians' orders for the medications of clients #1, #2 and #3. The FPM did not ensure the required physicians' orders were obtained for the medications administered. Interview on 3/30/22 with staff #1 revealed: -rarely saw the FPM; -since she began employment, "can count on one hand how many times I saw him;" -"there was no leadership, we did it on our own;" -there was very limited information from the FPM; -the FPM was "very hands off." Interview on 3/28/22 with staff #2 revealed: -the facility opened up with certain systems not in place; -got no answers or half answers from the FPM when she went to him with questions. Interview on 3/22/22 with the Team Lead(TL) #1 revealed: -worked as first shift Team Lead; -started 1/10/22; -job duties included transporting clients to the day treatment, shopping for the facility, daily operations of the facility, back-up shift work and participating in CFT(Child and Family Team) meetings; -did anything the FPM asked him to do; -"when I came on board, I was asking what was my responsibility?" to the FPM; -the FPM "was very vague and so I just ran with my experience;" -the FPM "emailed me to cover this CFT meeting			

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V 109	Continued From page 4 or there is a med(medication) pickup;" -"I told him some goals(for clients) won't populate(in the electronic system) and he said he would take care of it." Interview on 3/22/22 with the TL#2 revealed: -started June 2021; -job duties included set expectations, supervise clients and daily operations of the facility on second shift; -had concerns with the FPM; -there was a lack of communication with the FPM; -felt the FPM was not that responsive to incidents. Additional interview on 3/22/22 with the Executive Director revealed: -he was not over the facility prior to 3/18/22; -he will be stepping in to handle the issues at the facility along with the VP of Residential Services; -the FPM is no longer employed. This deficiency is cross referenced into 10A NCAC 27G .1701 Residential Treatment Staff Secure for Children or Adolescents-Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 109		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this	V 110	When we were notified of the incident statements were gathered the staff member in question and from the client directly involved. Statements were also taken from staff witnesses and client witnesses and video footage was reviewed. Upon examining the evidence the employee was suspended and internal process for investigation began as well the notification of external parties. The employee has been terminated. Additional steps taken included: Program staff have been reminded of therapeutic expectations when addressing clients and engaging in routine communication and behavioral interventions. TCI refresher trainings were completed in March and Handle with Care (HWC) training was completed on April 24, 2022. Technical assistance from the Learning and Development department was utilized to help train staff in "real time" with interventions and engaging with clients. Monthly supervisions for staff who require (PPs and APs) them will reflect or note issues observed during their work on the shift.	4/23/22

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V 110	Continued From page 5 Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure staff demonstrated knowledge, skills and abilities required by the population served for 4 of 8 current staff (#2, #3, #6 and Team Lead #2/TL#2). The findings are: Finding #1: Review on 3/25/22 of staff #3's personnel record revealed: -hire date of 12/6/21; -job title of Behavioral Health Counselor(BHC);	V 110		

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V 110		V 110		

Continued From page 6

-documentation of completion of required trainings was present in the record.

Interview on 3/28/22 with staff #4 revealed:
-started her job at the facility in 1/2022; - started on second shift and in the past two weeks, have worked first shift;
-one day she was working second shift;
-staff #1 came up asked her(staff #4) for advice; - staff #1 reported she(staff #1) had witnessed staff #3 mistreat client #2;
-staff #4 told staff #1 to report it;
-staff #4 spoke with client #2 and client #2 told her about the altercation with staff #3;
-not seen staff #3 anymore;
-staff #3 "was dropping the F-bomb(f**k) around the clients;"
-she told the Vice President(VP) of Residential Services all of this.

Interview on 3/30/22 with staff #1 revealed: - worked in the facility since 11/1/21 on second shift;
-saw a water bottle fly;
-did not see where it landed;
-saw staff #3 "body check" client #2;
-staff were using curse words around the clients;
-mostly staff #3;
-not heard any staff curse in awhile.

Interview on 3/28/22 with staff #2 revealed:
-just instructed clients to do hygiene and chores;
-told client #2 to do bathroom and trash;
-he was "giving a little pushback;"
-client #2 made a comment "b***h did not draw the line;"
-client #2 was walking back towards the bathroom;
-staff #2 was at the computer typing;
-staff #2 saw a water bottle fly,

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V 110		V 110		

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-saw staff #3 "chest bump" client #2;
-first thing she had seen from staff #3 to cause her concern.

Interview on 3/22/22 with client #2 revealed:
-staff #3 was a "butthole;"
-staff #3 threw a water bottle at him and pushed him into a corner;
-did not remember what other staff was working;
-did not know if any other clients saw it; -"she(staff #3) thought I was saying something about her;"
-he was going to clean the bathroom;
-staff #3 threw the water bottle and it missed.

Interview on 3/23/22 with staff #3 revealed:
-client #2 was very aggressive and very defiant;
-client #2 had gotten aggressive with her before;
-he'll get mad then he'll want to talk to her;
-she did toss a water bottle at him;
-he did not catch the bottle and it fell to the floor;
-client #2 got very upset and stormed off;
-never put her hands on client #2;
-never had to physically intervene with client #2.

Interview on 3/25/22 with the Vice President(VP) of Residential Services revealed:
-had allegations regarding staff #3;
-staff #3 has been suspended;
-client #2 said a water bottle was thrown by staff #3 at him and he did not catch it;
-client #2 also alleged staff #3 bumped him with her belly;
-staff #3 admitted to tossing the water bottle; -statements from clients and staff were varying; -continued to be an ongoing internal investigation.

Interview on 3/28/22 with Team Lead(TL) #2 revealed:
-"heard staff cuss in regular conversation;"

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V 110		V 110		

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-was staff #3;
-"words said too often in regular conversation;"
-had addressed it with staff #3;
-"in general, some people get too comfortable;"
-staff #3 would use curse words in her conversation;
-"her(staff #3) words could be a little strong;" -
"don't feel she(staff #3) was malicious with clients;"
-she(staff #3) needed "to learn when she needed to tap out."

Further interview on 3/30/22 with the VP of Residential Services revealed:
-termination paperwork was done on staff #3; -
termination meeting with staff #3 scheduled for Friday 4/1/22.

Finding #2:
Review on 3/21/22 of personnel records revealed:
-Team Lead #2 was hired on 5/4/21 and documentation of completion of required trainings was present in the record;
-staff #2 was hired on 7/31/21 with the job title of BHC and documentation of completion of required trainings was present in the record.

Interview on 3/28/22 with client #5 revealed:
-"staff do be cussing;"
-staff cursing in general.

Interview on 3/28/22 with client #6 revealed: -staff curse in general; -not disrespectful.

Interview on 3/28/22 with staff #2 revealed:
-have heard staff curse;
-not at clients;
-cursing in conversation;
-"everyone including myself;"

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V 110	Continued From page 9 -"throw in a h**l or a d**n in there;" Interview on 3/28/22 with staff #6 revealed: -admitted staff "do sometimes cuss in general;" -"I sometimes slip up;" -"we all are working on that as a whole house;" - not observed any staff being verbally abusive to any clients. Review on 3/28/22 of a form titled "Corrective Action" dated 2/25/22 completed by the FPM(Former Program Manager) regarding TL#2 revealed the following documented: - Violation of Company Policy; -happened on January 4th, 2022; -"In the milieu while working with clients, you utilized inappropriate language;" -"You will refrain from using profanity in the workplace while dealing with clients;" -"You are required to remain professional at all times;" -required to retake TCI(Therapeutic Crisis Intervention) course. This deficiency is cross referenced into 10A NCAC 27G .1701 Residential Treatment Staff Secure for Children or Adolescents-Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 110		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not	V 111	The client in question clinical profile was not articulated to the program staff in an effective manner by the former program manager, nor was the program manager effective in his planning to address the problem behaviors, and the client's presenting issues, such as the use of established protocols for safety or view the use of such interventions in an individualized manner. The former program manager did not complete his administrative tasks as the primary (QP) helping to assure that the CFT process was completed [updated, amended, scheduled] in the expected and successive manner. Nor did he complete the other administrative tasks of compiling client information post intake to enter into the record. (Macro) The program also reviewed the importance of gathering a greater degree of clinical and historical information with external stakeholders to assist in the treatment process. Meetings occurred with the MCO and DSS agencies in February, March, and April of 2022. These meetings will continue throughout the life of the program and are built into the structure of operations.	4/23/22

			In response the program implemented a process in which CFT dates are provided to all necessary stakeholders for a one month period. Stakeholder identification will occur pre and post intake. Correspondence will also be sent weekly to alert all parties of the meetings. CFT notes will be entered into the record and PCP amended as needed to reflect any changes in behaviors. Elements of residential and clinical management will review program and clinical documentation to measure the correlation between the client's presentation and current documentation in the record as well as the inclusion of historical information. The program has a procedure in place to search the personal items and effects of the client's entering the program and was not followed when the client entered the program initially or during subsequent re-entries back into the program. Routine search and seizure are performed but are limited in scope when maintaining privacy and client's rights. The program has also solicited law enforcement (CMPD) for K-9 assistance but that request was not granted due to the lack of causality. Search and seizure actions continue to be carried by program staff. The program staff are working on a discharge plan which will encompass substance abuse treatment, The referral is pending additional information from the legal guardian. The program instituted fifteen minute check sheets to assist with supervision and awareness of client location. (Micro) The client was placed on "Sexualized Behavior Precautions" on 3/31/22. The client's room and personal effects were subject to search and seizure.	

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V 111	Continued From page 10 be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented. This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure when services were provided prior to the establishment and implementation of the treatment plan, strategies to address the client's presenting problem were documented affecting 1 of 6 clients(#5). The findings are:	V 111		

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V 111	Continued From page 11 Review on 3/28/22 of client #5's record revealed: -admission date of 2/25/22; -age of 15 years; -diagnoses of Conduct Disorder, Generalized Anxiety Disorder, Major Depressive Disorder, Cannabis Use, Unspecified with unspecified cannabis-induced disorder, other reactions to severe stress and child neglect or abandonment; -admission assessment dated 12/22/21 documented client #5 had been in the Department of Social Services custody since 2019 for lack of supervision and care, was exposed to domestic violence and substance abuse by family members. Client #5 had a history(hx) of running away and a hx of criminal charges including over twenty breaking and entering charges, robbery with a weapon, injury to personal property, resisting arrest, possession of drug paraphernalia, possession of THC(Marijuana) and assault with deadly weapon. Client #5 had bought and smoked THC, engaged in sexual behavior with a female peer at a prior placement, exhibited gang mentality and made threats towards peers. Client #5 had a hx of multiple level placements and had weekly visits with his mother and siblings. -Crisis Plan dated 3/1/22 located in the therapy notes documented: "[Client #5] has a history of sexually inappropriate behaviors in group settings, ensure his bedroom door is open at all times, he must be supervised closely around female peers." -there were no documented strategies addressing client #5's substance abuse history and his sexually inappropriate behaviors with female peers. Interview on 3/28/22 with client #1 revealed: -saw client #6 had a hickey; -client #6 did not say where she got it from;	V 111		

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ALEXANDER TRANSITION HOUSE	6324 THERMAL ROAD CHARLOTTE, NC 28211

(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 111		V 111		
	Continued From page 12 -client #5 and client #6 are boyfriend and girlfriend; -"they have just been dating here;" - staff aware they are dating. Interview on 3/28/22 with client #4 revealed: - client #5 and client #6 had sex together in the closet in the game room; -she was their lookout; -client #5 and client #6 also were smoking vapes(electronic cigarette device) together; -she saw client #5 pass the vape to client #6; - client #6 went to bathroom and smoked a couple of times and she came out high; -it was the gray and white vape. Interview on 3/28/22 with client #6 revealed: -client #5 was her boyfriend; -had sex twice in the closet with client #5 at the facility. Interview on 3/28/22 with client #5 revealed: - sometimes had sexual interaction in the closet of the game room with client #6; -don't know how many times; -"always sneaky;" -"ain't got no vapes no more;" -had vapes when he came; -staff checked his stuff and could not find it; -"vape was dead;" -not had any THC while here. Review on 3/28/22 of a urine drug screen for client #5 dated 3/25/22 revealed client #5 tested positive to THC. Review on 3/28/22 of a handwritten statement dated 3/23/22 and completed by staff #4 revealed the following documented: -client #4 informed staff #4 that client #5 and			

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V 111	Continued From page 13 client #6 had intercourse on at least two different occasions in the closet game room area; -client #4 also reported client #5 had a "weed pen(electronic device used to vaporize THC)" on him that he got from home; -client #4 also reported client #5 had been "toking(smoking) it in the bathroom." Review on 3/28/22 of a therapy note dated 3/24/22 regarding client #5 revealed the following documented: -"met with client for individual therapy around healthy boundaries and following rules;" -"client reported frustration that he and a female peer have been separated in the past week due to the female client having a hickey on her neck;" -"client gave vague answers implying that he and the peer had engaged in sexual intercourse 'multiple times this week'." This deficiency is cross referenced into 10A NCAC 27G .1701 Residential Treatment Staff Secure for Children or Adolescents-Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 111		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (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. (d) The plan shall include: (1) client outcome(s) that are anticipated to be	V 112	The client in question clinical profile was not articulated to the program staff in an effective manner by the former program manager, nor was the program manager effective in his planning to address the problem behaviors, and the client's presenting issues, such as the use of established protocols for safety or view the use of such interventions in an individualized manner. This also includes the creation of Crisis Plans, and the RI process. The former program manager did not ensure the continuity of the information sharing and documentation of treatment changes or behavioral concerns in the client record. The following steps were taken in response (Micro-individualized) The client was placed on a set of protocols for safety to address the safety concerns she presented. The client's therapist continued to update and complete clinical documentation to reflect current presentations. (macro) In response the program implemented a process in which CFT dates are provided to all necessary stakeholders for a one month period. Stakeholder identification will occur pre and post intake. Correspondence will also be sent weekly to alert all parties of the meetings. CFT notes will be entered into the record and PCP amended as needed to reflect any changes in behaviors.	4/23/22

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V 112	Continued From page 14 achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (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. This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to develop and implement strategies to address client needs for 1 of 6 clients(#6). The findings are: Review on 3/28/22 of client #6's record revealed: -admission date of 2/9/22; -age of 15 years; -diagnoses of PTSD(Post Traumatic Stress Disorder), Major Depressive Disorder, Opioid Dependence, uncomplicated and ODD(Oppositional Defiant Disorder); -admission assessment dated 1/10/22 documented client #6 had been in the Department of Social Services custody since 2019 and had multiple placements. Client had a hx(history) of self harm and suicidal ideation.	V 112		

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V 112	Continued From page 15 Client #6 disrupted her prior placement due to a fight with a peer. Client #6 had a hx of sexual abuse by her father, intrusive thoughts, nightmares, low affect, depression, sexual promiscuity, defiance and aggression. Client #6 also had a hx of substance abuse including use of Xanax, THC(marijuana), Percocet and alcohol; -treatment plan dated 10/23/21 documented goals to increase positive behaviors, become more self-sufficient, have no outbursts with fewer than three verbal prompts, complete personal hygiene, get along with peers, focus on doing well in school, explore careers and involve self in community; -staff strategies included guidance, redirection, psycho-educational rewards, consequences, supervision and structure, utilization of behavior management techniques, creation and implementation of interventions, teach individual living skills and effective coping skills, crisis support, opportunities to learn restorative living skills, social skills, leisure skills and health/wellness; -no strategies/goals for sexual behaviors or substance abuse in the treatment plan or the crisis plan. Interview on 3/28/22 with client #1 revealed: -saw client #6 had a hickey; -client #6 did not say where she got it from; -client #5 and client #6 are boyfriend and girlfriend; -"they have just been dating here;" -staff aware they are dating. Review on 3/28/22 of a handwritten statement dated 3/23/22 and completed by staff #4 revealed the following documented client #4 informed staff #4 that client #5 and client #6 had intercourse on at least two different occasions in the closet game	V 112		

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V 112		V 112		

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room area.

Interview on 3/28/22 with staff #4 revealed:
-found a vape(electronic cigarette device) on Saturday 2/26/22 in client #6's room when she did a room search;
-the vape was broken apart;
-was in four pieces;
-could not tell if it once had THC in it.

Interview on 3/28/22 with client #4 revealed: -
when client #5 went on his home visits, he brought back vapes;
-he gave the vapes to his girlfriend client #6;
-have seen it;
-he had one vape with THC in it;
-there was a red vape and a white vape with green on it;
-client #5 asked her to be a lookout;
-she said ok;
-client #5 and client #6 went to closet where the games were kept;
-she saw them having intercourse and client #6 "she sucked his thingy(penis)"
-"about a minute and some change"
-client #6 had a hickey on her neck;
-she saw client #5 pass the vape to client #6; -
she went to bathroom and smoked a couple of times and she came out high.

Review on 3/28/22 of a urine drug screen for client #6 dated 3/24/22 revealed client #6 tested positive for THC.

Interview on 3/28/22 with client #6 revealed:
-client #5 was her boyfriend;
-had sex twice in the closet with client #5 at the facility;
-not smoked any vapes;
-denied client #5 gave her vapes;

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V 112	Continued From page 17 -don't know if client #5 had vapes. Interview on 3/28/22 with client #5 revealed: -sometimes had sexual interaction in the closet of the game room with client #6; -don't know how many times; -"always sneaky." This deficiency is cross referenced into 10A NCAC 27G .1701 Residential Treatment Staff Secure for Children or Adolescents-Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure disaster drills were held at least quarterly and repeated for each shift. The	V 114	There is a written plan in place for both emergencies and disasters, at an agency wide, organizational, and program level. Fire Drills and Disaster Drills were not completed by the previous program manager as required for licensure and mandated by agency procedure. The staff in the program were not trained on how to complete the tasks as required and not educated on the process of conducting drills. The staff were trained on how to complete Disaster Drills and Fire Drills the last week of March 2022. Currently drills are completed monthly as required and copies of the drills are stored* in the "Program Manager's" office in labeled binders with copies of the respective plans in their designated binders. Drills have been completed for the months of March and April. The emergency kit and supplies have been placed in a central location accessible to all staff on duty.	5/15/2022

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V 114		V 114		

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findings are:

Interview on 3/22/22 with the Team Lead(TL) #2 revealed:
-the facility ran three shifts;
-started getting clients in 12/2021.

Review on 3/22/22 of the facility's documentation of fire and disaster drills from 12/1/21-3/22/22 revealed no disaster drills documented as conducted.

Further interview on 3/22/22 with the TL#2 revealed:
-have done fire drills;
-have not done any disaster drills.

Interview on 3/22/22 with client #1 revealed: -came to the facility after the holidays; -have not done a disaster drill.

Interview on 3/22/22 with client #2 revealed:
-came to the facility after Christmas;
-did a fire drill;
-not done a disaster drill.

Interview on 3/22/22 with client #3 revealed:
-did a fire drill;
-no disaster drills;
-only do disaster drills at his day program.

Interview on 3/23/22 with staff #2 revealed: -worked at the facility since 11/2021 on 2nd shift; -done fire drills but no disaster drills.

Interview on 3/24/22 with the Former Program Manager(FPM) revealed:
-did a few fire drills;
-did do a tornado drill;
-"wouldn't know where it is(documentation for

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V 114	Continued From page 19 tornado drill)."	V 114		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118	Medication entering the program was not being introduced in the correct manner. The former program manager did not understand or attempt to create a process to assure the program's compliance. It should be noted that it is the program's responsibility to assure that medication documentation (physician's orders, consents, prescriptions, MARs, and any other applicable forms/records) be maintained and managed. This process includes communication with the legal guardian to insure that licensure requirements are followed (medication orders), as well as maintaining the medication for the clients. The program has taken steps to assure that all documentation that is required for medication is obtained prior to admission. This step was communicated to stakeholders in successive meetings, those meeting included the respective DSS agencies and the MCO. Physician's orders will be verified and obtained prior to or at admission/intake. At that time medications will be verified and inventoried and accepted into the program. The program also created a new process of Medication Administration which will seek to improve the process and reduce errors and concerns. This process will include the creation of an "MAR Auditor". This designee will review the MAR daily checking behind all shifts for errors and concerns. This designee will be the only party to complete incident reports (internal and external) regarding medication issues. This designee will forward all daily errors and incident reports to the program manager to address. The "MAR Auditor" will also be present at intake to complete the inventory of medications and review all documentation. There will be one designates staff person who will pick up all medications from local pharmacies. Controlled medications of discharged clients will be disposed of through the mail in process, with USPS receipts stored with the discharged MAR. The program will continue to train all staff to administer medications, but will limit the number of staff passing medications to seven, two on each shift, a primary and a secondary, along the with "MAR Auditor". All other staff will serve in a purely contingent capacity. MAR refresher training will take place quarterly, trained and presented through the Nursing Department. Other programmatic changes will include the creation of physical location solely dedicated to the MAR process.	4/23/22

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V 118		V 118		

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This Rule is not met as evidenced by: Based on records review, interview and observations, the facility failed to ensure medications were administered to a client on the written order of a person authorized by law to prescribe drugs and a MAR of all drugs administered to each client was kept current affecting 3 of 6 clients(#1, #2 and #3). The findings are:

Finding #1:
Review on 3/18/22 and 3/22/22 of client #1's record revealed:
-admission date of 2/7/22;
-age of 13 years;
-diagnoses of ADHD(Attention Deficit Hyperactivity Disorder), PTSD(Post Traumatic Stress Disorder) and DMDD(Disruptive Mood Dysregulation Disorder);
-no physicians' orders were present in the record for any medications.

Observation on 3/22/22 at 11:56am of client #1's medications revealed:
-Concerta 27mg(milligrams) one daily dispensed 3/3/22 for ADHD;
-cetirizine 10mg one daily dispensed 3/9/22 for allergies;
-ziprasidone 60mg one tablet in the morning and one tablet at night dispensed 3/4/22 for anxiety and depression;
-ferrous sulfate 325mg one tablet at night over the counter(OTC) expiration date of 11/2024 for iron deficiency;
-Melatonin 5mg two tablets as night OTC expiration date of 11/2023 for sleep; -guanfacine 3mg one tablet in the morning dispensed 3/3/22 for ADHD.

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V 118	Continued From page 21 Review on 3/22/22 of client #1's MARs from 2/7/22 until 3/22/22 revealed all above listed medications documented as administered with no physicians' orders. Finding #2: Review on 3/18/22 and 3/22/22 of client #2's record revealed: -admission date of 2/15/22; -age of 14 years; -diagnoses of ADHD, Unspecified Disruptive Impulse Control, Conduct Disorder and Unspecified Trauma and Stressor Related Disorder; -no physicians' orders were present in the record for any medications. Observation on 3/22/22 at 12:15pm of client #2's medications revealed: -sertraline 25mg one tablet in the morning dispensed 2/23/22 for anxiety and depression; -methylphenidate 5mg one and a half tablet twice daily dispensed 2/28/22 for ADHD; -gabapentin 300mg one tablet three times daily dispensed 2/22/22 for anxiety; -Clonidine 0.2mg one tablet at bed dispensed 2/22/22 for ADHD; -risperidone 3mg one tablet at bed dispensed 2/22/22 for mood. Review on 3/22/22 of client #2's MAR from 2/15/22-3/22/22 revealed: -sertraline 25mg, gabapentin 300mg, Clonidine 0.2mg and risperidone 3mg documented as administered from 2/22-3/22 with no physicians' orders; -methylphenidate 5mg documented as administered from 2/15-3/22 with no physician's order.	V 118		

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V 118	Continued From page 22 Finding #3: Review on 3/18/22 and 3/22/22 of client #3's record revealed: -admission date of 2/4/22; -age of 10 years; -diagnoses of PTSD, DMDD and ADHD; -no physicians' orders were present in the record for any medications. Observations on 3/22/22 of client #3's medications revealed: -Lactulose 15ml daily dispensed 2/4/22 for constipation; -lamotrigine 25mg two tablets in the morning dispensed 3/16/22 for mood; -Melatonin 10mg one tablet as needed at bed OTC with expiration date of 3/2023 for sleep; -guanfacine 4mg one tablet at bed dispensed 3/16/22 for ADHD. Review on 3/22/22 of client #3's MARs from 2/4/22-3/22/22 revealed: -Lactulose 15ml documented as administered from 2/4-3/14, 3/15, 3/17-3/22 with no physician's order; -the dosing dates of 3/14 and 3/16 were left blank with no explanation on the MAR for Lactulose 15ml; -lamotrigine 25mg two tablets documented as administered from 3/17-3/22 with no physician's order; -lamotrigine 25mg one tablet documented as administered from 2/4-3/16 with no physician's order and stopped with no discontinue order; -Melatonin 10mg documented as administered on 3/21 with no physician's order; -guanfacine 4mg documented as administered from 3/16-3/21 with no physician's order; -guanfacine 3mg documented as administered	V 118		

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V 118	Continued From page 23 from 2/4-3/15 with no physician's order and stopped with no discontinue order. Interview on 3/22/22 with Team Lead #1(TL#1) revealed: -the Former Program Manager(FPM) was supposed to handle the medications; "he will tell us pick up medications;" -the Department of Social Services Social Workers(DSS SWs) "would tell us the client has meds(medications) at the pharmacy;" -the FPM gave him medication scripts and told him to take the scripts to the pharmacy; -was never told to keep a copy of the medication script for the client records by the FPM. Interview on 3/22/22 with TL#2 revealed: - the DSS SWs took clients to medication management off-campus; -the DSS SWs brought the clients back with medication scripts; -took the medication scripts to the local pharmacy to be filled; -was never told to get copies of the scripts for the medications by the FPM. Interview on 3/24/22 with the FPM revealed: -had assigned meds to his Team Leads to review MARS, get med refills and notify DSS SWs when needed refills; -also had third shift reviewing meds; -"meds became such an issue;" -med orders "were all our responsibility;" -"falls on [local management entity/LME] to have the med orders when clients are admitted, [LME] arranges the placement;" -had to reach out to DSS to try to get med orders; -some of the clients came from the hospital with discharge papers that listed the client medications;	V 118		

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V 118	Continued From page 24 -not sure of the location of the discharge papers; - may have to pull the hospital discharge papers from his old office; -he no longer worked at the facility. Interview on 3/22/22 and 3/25/22 with the Executive Director revealed: -he was unaware there were no physician orders for the medications in the records; -"my nursing team did the training and they confirmed they had explained all that to the prior Program Manager(FPM) about having med orders;" -he was unaware Team Leads knew nothing about getting med orders; -will ensure all medication orders are obtained from the pharmacy; -will send a request to the pharmacy today for all medication orders. This deficiency is cross referenced into 10A NCAC 27G .1701 Residential Treatment Staff Secure for Children or Adolescents-Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 118		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (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.	V 131	Human Resources (HR) is responsible for HCPR checks when a prospect employee has received their conditional job offer. Prior to their identified start date internal/external background, driving record and HCPR checks are completed. Upon completion of a satisfactory background check, these checks are conducted on an annual basis. Failures with this process occurred as a result on continued staff turnover within our HR department. In October 2021 the new HR team began rebuilding. Clean up occurred immediately as the team continued to grow. It was determined that HCPR checks were tasks that were not completed and followed up on. On 4/28/21 a meeting occurred with the member of HR that conducts the checks, VP of Residential Services and the Performance Improvement Manager to ensure the previous process that was in place would be maintained. At the time the HR department is conducting an internal audit to ensure all staff have updated annual checks.	5/10/22

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V 131	Continued From page 25 This Rule is not met as evidenced by: Based on records review and interview, the facility failed to access the Health Care Personnel Registry(HCPR) prior to hire for 2 of 8 current staff(#1 and #2). The findings are: Review on 3/18/22 and 3/21/22 of personnel records revealed: -staff #1 was hired on 7/21/21 with the job title of BHC(Behavioral Health Counselor) and the HCPR was accessed on 7/26/21; -staff #2 was hired on 7/13/21 with the job title of BHC and the HCPR was accessed on 7/26/21. Interview on 3/30/22 with the Executive Director revealed: -HR(Human Resources) Department has all new staff; -HR in process of trying to organize the personnel records; -not aware the HCPR checks were late.	V 131		

V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE (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. (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	V 293	The former program manager did not make sure the staff in the program understood the process and importance of line of sight supervision. The staff were counseled and shown how to supervise clients, this included positioning, rounding, and looking at the clients and knowing the whereabouts of clients at all times. Therapeutic boundaries were included as a focus of group supervision as well. Boundaries are a key element of supervision. The focus of group supervision on March 31st, April 7th, and April 14th, included line of sight supervision. The program implemented fifteen minute check sheets on all three shifts. Staff are expected to remain awake at all times and program management will monitor for prohibited behavior as needed. Staff are expected to maintain therapeutic boundaries in all communications with program clients. TH program BHC job descriptions were amended to reflect the expectations in regard to boundaries and supervision (listed as KPIs). Those KPIs will be reviewed during monthly supervisions in the E3 system. Amended job descriptions were approved and implemented by HR in April of 2022. TCI refreshers were completed in March 2022 and Handle With Care (HWC) training was completed on 4/28/22.	4/23/22

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V 293	Continued From page 26 this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or 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. (d) The children or adolescents served shall require the following: (1) removal from home to a community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting.(e) Services shall be designed to: (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care.	V 293		

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V 293		V 293		
	Continued From page 27 This Rule is not met as evidenced by: Based on records review, observations and interviews, the facility failed to provide intensive, active therapeutic treatment and interventions within a system of care approach with continuous supervision and services designed to minimize the occurrence of behaviors related to functional deficits affecting 6 of 6 clients(#1, #2, #3, #4, #5, #6). The findings are: Cross reference: 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS(V109) Based on records review and interviews, the facility failed to ensure 1 of 1 Former Qualified Professional (Former Program Manager/FPM) demonstrated knowledge, skills and abilities required by the population served. Cross reference: 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS(V110) Based on records review and interviews, the facility failed to ensure staff demonstrated knowledge, skills and abilities required by the population served for 4 of 8 current staff (#2, #3, #6 and Team Lead #2/TL#2). Cross reference: 10A NCAC 27G .0205(a-b) ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN(V111) Based on records review and interviews, the facility failed to ensure when services were provided prior to the establishment and implementation of the treatment/habilitation or service plan, strategies to address the client's			

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V 293		V 293		

Continued From page 28

presenting problem were documented affecting 1 of 6 clients(#5).

Cross reference: 10A NCAC 27G .0205(c-d) ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN(V112) Based on records review and interviews, the facility failed to develop and implement strategies to address client needs for 1 of 6 clients(#6).

Cross reference: 10A NCAC 27G .0209(c) MEDICATION REQUIREMENTS(V118) Based on records review, interview and observations, the facility failed to ensure medications were administered to a client on the written order of a person authorized by law to prescribe drugs and a MAR of all drugs administered to each client was kept current affecting 3 of 6 clients(#1, #2 and #3).

Cross reference: 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS(V296) Based on interviews, the facility failed to ensure three direct care staff were present when five, six, seven or eight clients were present and awake.

Observation on 3/22/22 at 2:50pm of the facility revealed:
-one level facility;
-front door led to a large living room area;
-on the far wall of the living room were two glass doors;
-the two glass doors led to a game room;
-to the right of the glass doors in the game room was a closet with two doors;
-the closet had various board games and recreational games in it;
-a table was sitting in front of the wall between the living room and the game room with a computer

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V 293		V 293		
	Continued From page 29 on it; -staff was sitting at the table in front of the computer with back to the game room facing out to the living room. Interview on 3/28/22 with client #2 revealed: -"I was playing a game and looked back and saw one of the girls rubbing on one of the guys;" -he looked back and "tried to play it off like I didn't see it;" -did not say anything to staff; -it was yesterday during the day on first shift; -he, the girl and the guy were in the game room; -"we were playing the same game;" - staff were in the living room; -staff did not notice it happening; -identified the girl as client #6 and the guy as client #5; -client #6 was rubbing on client #5's private area; - Team Lead(TL) #1 and staff #5 were working yesterday when it happened. Interview on 2/28/22 with client #4 revealed: - when client #5 went on his home visits, he brought back vapes(electronic cigarette device) and gave the vapes to his girlfriend (client #6); -he showed client #4 the vapes; -they were in the game room when he showed the vapes to her; -made sure staff were not looking; -only client #5, client #6 and her were in the game room on first shift; -it was 2-3 weeks after she came to the facility; -client #5 asked her to be a lookout; -she said ok; -client #5 and client #6 went to the closet where all the games are kept and had sex; -she was sitting in a chair by the door to the game room; -client #5 and client #6 were in the game room			

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V 293		V 293		
	Continued From page 30 closet "about a minute and some change;" -staff were sitting down doing computer work out in the living room; -staff #5 and staff #4 were working; -Team Lead(TL) #1 was in a meeting in the therapy room; -staff #5 was at the big table doing his work on the computer and his back was facing the door to the game room; -staff #4 was doing her work on the computer; -don't remember where staff #4 was sitting; -client #6 had a hickey on her neck not too long ago; -yesterday client #5 and client #6 used the vape; -she saw client #5 pass the vape to client #6 in the living room; -staff confiscated one of the vapes; -client #5 keeps the gray vape in his pocket. Interview on 3/28/22 with client #5 revealed: -sometimes had sexual interaction in the closet of the game room with client #6; -don't know how many times; -"always sneaky;" -staff were in the living room area on their computers doing notes or on their phones; -"it would be different staff." Interview on 3/28/22 with client #6 revealed: -had a hickey from her boyfriend; -client #5 was her boyfriend; -had sex with client #5 in the game room; -client #4 was with them; -staff was at the table in front of the entrance to the game room; -staff had their back to them; -had sex twice in the game room closet with client #5; -second time staff were in the same place when she and client #5 had sex;			

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V 293		V 293		
	Continued From page 31 -don't remember what staff was working; - in the closet for five minutes both times. Interview on 3/28/22 with staff #5 revealed: -aware client #5 and client #6 liked each other; -a week ago, saw client #6 had a hickey on her neck; -he said something to client #6 about it and she said it was a birthmark; -he went up to her to see what it was; -he told her since her mother called every morning, he would talk to her mother about it; -client #6 never admitted it was a hickey. Interview on 3/28/22 with staff #2 revealed: -took vapes off of client #5 when he first came; -haven't seen any since; -she did see a hickey on 3/21/22 on client #6; -she asked client #6 how did she get it; -client #6 said client #5 gave it to her; -client #6 did not say when she got it, Interview on 3/28/22 with TL#2 revealed: -found some vapes in the beginning and confiscated those when client #5 was first admitted; -recently, a vape was found on client #6 this weekend, -believe given to her by client #5, -client #5 visited his mother on the weekends; -"we did a room sweep but can't do a body search;" -client #5 did not go for a visit this weekend; -client #5 and client #6 both tested positive for THC; -client #6 had not left the facility; -client #6 had a hickey discovered on first shift; -he did not see the hickey that day before on second shift; -he talked to client #6 the same day he saw the			

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V 293	Continued From page 32 hickey; -client #6 told him it happened when staff wasn't looking; -she did not admit to sexual intercourse but did admit to kissing; -she said she was in the game room; -client #5 said he did not want to say anything; - mentioned in client #5's documentation about him having sex with female peers at a prior placement. Interview on 3/30/22 with the Vice President(VP) of Residential Services revealed: -got a metal wand detector now to use in the facility for purposes of detecting contraband on clients; -termination paperwork done on staff #3 and termination meeting with her on Friday 4/1/22; - having local police come out with the canine dog to ensure no drugs still hidden at the facility; - client #6 now has a 1:1 staff who stays within arms length to address her sexualized behaviors; -did a pop in visit last night to observe and monitor third shift, -was at the facility until 2am. Interview on 3/30/22 with the Executive Director revealed: -already met with staff to discuss expectations and go over issues; -had therapist develop strategies to address the client behaviors and implement with staff. Review on 3/30/22 of a Plan of Protection dated 3/30/22 completed by the Executive Director revealed the following documented: - "As of 3.30.22, Alexander Youth Network(licensee) has taken the following measures to ensure safety and care of our consumers:	V 293		

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V 293	Continued From page 33 The Transition House Program Manager (former) was terminated as of 3/22/22. The VP of Residential Services and Executive Director of Residential Services will assume the role until a replacement program manager has been identified. VP of Residential Services and Executive Director will complete on-site check-ins across each shift which began 3/29/22. Staff #3 is currently suspended and termination proceedings are scheduled for 4/1/22. On 3/24/22, the VP of Residential Services met with the Transition House staff members to discuss and review general work rules and expectations of staff. The VP of Residential Services has a second meeting scheduled for 3/31/22 to address: use of Therapeutic Crisis Interventions (TCI), therapeutic interactions and treatment, effective supervision, and collaboration with clinical team to ensure effective use/implementation of clinical skills. Transition House QP will participate in PCP and crisis plan development training within the next 21 days. Executive Director has obtained doctor orders for all current Transition House consumers as of 3/23/22. Transition House staff will also be scheduled for Medication Administration training within the next 21 days. Additionally, the VP of Residential Services has reviewed the intake packet to require doctor orders from guardian during the admission process. The VP of Residential Services and Transition House staff have conducted search and seizure to identify potential contraband within the facility. Client #5 and Client #6 have completed drug testing at an off campus site. Sexualized behavior precautions have been implemented for both client #5 and client #6 as of 3/29/22. All Transition House staff have been informed of the precautions and provided with the	V 293		

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parameters in which need to be followed during the precaution status.
The VP of Residential Services has revised the staff schedule to include at least three staff on shift during awake hours."
-"In order to ensure that the above happens:
The scheduled trainings will be documented and confirmed via sign in sheet.
The search and seizure will be completed as needed to ensure consumer health and safety.
Each precaution status will be reviewed every 24hrs by a licensed clinician who will determine when the consumer is able to be removed from the precaution status."

Clients #1, #2, #3, #4, #5 and #6 had diagnoses which included PTSD(Post Traumatic Stress Disorder), ADHD(Attention Deficit Hyperactivity Disorder), DMDD(Disruptive Mood Dysregulation Disorder), ODD(Oppositional Defiant Disorder), Conduct Disorder, Impulse Control Disorder, Anxiety Disorder, Depressive Disorder, Cannabis Use Disorder and Opioid Dependence and ranged in age from 10 years to 17 years. Clients #1, #2, #3, #4, #5 and #6 displayed behaviors which included sexualized behaviors, substance abuse, aggression, self-harm, suicidal ideation, impulsivity, poor boundaries and criminal activity. Client #5 and client #6 admitted to engaging in sexualized behavior at the facility on at least two occasions. The sexual interaction occurred when staff were not supervising the clients. An incident of sexual touching occurred between client #5 and client #6 on 3/27/22 when only two staff were working first shift with six clients witnessed by client #2. Client #5 and client #6 both tested positive to marijuana and were engaging in substance abuse at the facility. Client #4 witnessed the sexual interaction and the substance abuse of client #5 and client #6 at the

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V 293	Continued From page 35 facility. No strategies were put in place to prevent the sexualized behaviors and the substance abuse of client #5 and client #6 although both had extensive histories of these behaviors upon admission. Staff were using profanity around the clients. Staff #3 threw a water bottle and bumped into client #2 with her body. There were no medication orders for any medications administered to clients. The FPM was responsible for developing and implementing strategies to address client behaviors and was responsible for ensuring medication orders were obtained for all medications administered. The FPM did not provide clear expectations of job duties and responsibilities for his staff. The lack of strategies to address client behavioral and mental health issues, the lack of appropriate staffing and supervision, the lack of competency of the staff and the FPM and the lack of medication orders constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 293		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows:	V 296	The former program manager did not guarantee that the ratio requirements were met consistently and did not complete the program schedule in a manner required by licensure and by agency policy. The Program Manager will complete and maintain the program schedule to meet the ratio and coverage needs of the program in accordance with 10A NCAC 27G, 1704 "Minimum Staffing Requirements". In response the program has noted and informed staff of QPs within thirty minutes (VP of Residential Services, TH Program Manager, Charlotte PRTF ED, and Charlotte PRTF Supervisory staff). Direct care staff have been directed to alert the QP staff listed above beginning with the Program Manager in reference to shift coverage.	4/23/22

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V 296	Continued From page 36 (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan. This Rule is not met as evidenced by:	V 296		

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	MHL0601494	A. BUILDING: _____ B. WING _____	03/31/2022

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V 296	Continued From page 37 Based on interviews, the facility failed to ensure three direct care staff were present when five, six, seven or eight clients were present and awake. The findings are: Interview on 3/22/22 and 3/28/22 with client #2 revealed: -woke up around 7:30am and two or three staff were present at the facility; -went to bed 9:00-9:30pm and two or three staff were present at the facility; -when he got back to the facility from school during the week at 1:30pm there were two to three staff; -Team Lead(TL) #1 and staff #5 were at the facility yesterday(3/27/22); -they worked first shift; -all six clients were present at the facility yesterday. Interview on 3/28/22 with client #4 revealed: -Team Lead(TL) #1 and staff #5 worked first shift yesterday(3/27/22); -all six kids were at the facility; -no other staff working on first shift. Interview on 3/28/22 with client #1 revealed: -yesterday first shift was TL#2 and staff #5; -"that's all that worked first shift." Interview on 3/30/22 with staff #1 revealed: -worked in the facility since 11/1/21 on second shift; -have worked some shifts with just two staff and six kids; -happened three times. Interview on 3/28/22 with staff #5 revealed: -worked yesterday first shift; -TL#1 worked with him;	V 296		

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V 296	Continued From page 38 -"all six kids were here;" -was two staff on shift, but now added a third staff. Interview on 3/28/22 with staff #2 revealed: -not enough staff this past weekend; -had two staff on second shift and had a floater; -TL#2 came in because he saw two people were not enough; -TL#2 came in Saturday and Sunday to work; -during the week staffing on second shift was ok. Interview on 3/28/22 with TL#2 revealed: -he had three to four staff working on his shift; -"this week was a little tough;" -had to come in and work the weekend; -originally scheduled two people for the weekend; -"in case of a crisis not adequate staff to handle so I stepped up." This deficiency is cross referenced into 10A NCAC 27G .1701 Residential Treatment Staff Secure for Children or Adolescents-Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 296		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (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	V 367	Upon review of the late submissions, the team identified the cause of late submission was due to a lack of training and oversight by the former Program Manager and his inability to correct errors and review program documentation timely. The former program manager did not create a process to identify an alternative option when he is unavailable or unable to review incident reports. Delegation of duties in the manner of the former program manager is unacceptable and will not be condoned in the future under any structure of program management. Additional measures have been identified and implemented to prevent ongoing late incident submissions. This process will utilize existing QPs to review incident reports and program documentation, the performance improvement process, and elements of residential and operations management. Residential and operational managers provided training for program staff on April 7th and 14th [2022] to address Incident Reporting. The training will identify: categorizing incident levels, required internal and external contacts, and timeframes in which reports have to be submitted. Incident reporting will be a focus of weekly program meetings. The Program Manager and shift leads (QPs) will review the standard protocols related to Incident	5/15/22

			Reporting and Restrictive Interventions. When an incident report is completed, the staff will notify the shift lead, and Program Manager immediately following the incident. The Program Manager or designated QP will review the incident report to determine the appropriate level classification and proceed with completion of IRIS reporting if necessary. If the incident is a Restrictive Intervention, the initiating staff member will note the times and conduct the post intervention monitoring, and record and information and inform the Program Manager of the Restrictive Intervention (RI). In the event of illness or vacation, the Program Manager will indicate via email which individual or designated QP to be notified by staff when an RI is used. Once the Program Manager or designated QP has been notified of the incident, assessed the incident as a Level II or Level III incident, said supervisor will submit the IRIS report within 72hrs. The Program Manager will review the Electronic Health Record (EHR) to ensure that all IRIS reports have been submitted and an IRIS reporting number has been secured and logged into the EHR system. VP of Residential Services will review twice weekly. Additionally, program incident reports will be reviewed within the existing structure of the performance improvement team and consult with the VP of Residential Services.	

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V 367	Continued From page 39 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: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (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: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (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	V 367		

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V 367	Continued From page 40 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). (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: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area;(4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (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. This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure all level II incidents were	V 367		

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V 367	Continued From page 41 reported to the LME responsible for the catchment area where services were provided within 72 hours of becoming aware of the incident. The findings are: Review on 3/18/22 of the facility's incident reports from 1/1/22-3/18/22 revealed: -2/11/22 client #3 behaviors and police called; -3/11/22 client #2 behaviors and police called; -2/21/22 restraint performed on former client #7; -2/24/22 restraint performed on client #2; - 3/2/22 restraint performed on client #2. Review on 3/23/22 of IRIS(Incident Response Improvement System) from 1/1/22-3/18/22 revealed: -checked by county location of the facility and no incident reports found; -checked by each clients' name and no incident reports found; -checked by the facility name and no incident reports found; -checked by the parent agency name and no incident reports found. Interview on 3/24/22 with the Former Program Manager(FPM) revealed the Team Leads were supposed to put the reports in IRIS but the Teams Leads needed training in how to do IRIS. Interview on 3/25/22 with the Executive Director revealed: -met with FPM about IRIS and how to do it; -the FPM's response was to delegate everything to the Team Leads; -the FPM just wasn't doing it; -unaware the reports were not entered in IRIS.	V 367		

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V 736	Continued From page 42	V 736		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on record review, observations and interviews, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Review on 3/18/22 of the facility's incident reports from 1/1/22-3/18/22 revealed: -incident report dated 3/11/22 regarding client #2; -client #2 went outside without permission; -staff advised client #2 to put down the sticks; -client #2 walked around the facility and knocked out a window; -then he broke a different window; -staff kept him in their line of sight; -police were called; -client #2 took off into the woods; -staff found him and brought him back; -client #2 was calm after returning to the facility. Interview on 3/22/22 with client #2 revealed there was a broken window in the bedroom next to him, Observations on 3/22/22 at 2:50pm revealed: -last bedroom on the left on the left hall of the facility; -double paned window;	V 736	The broken window has been repaired. The facility has a system in place to repair physical plant damage. All property damage repairs must be submitted through the KACE-IT Ticketing system. Property damage will be assessed by using the environmental check sheet. That document will be used daily by a designated staff person to note any changes throughout the physical plant. Changes will be noted on the form, and then entered into the KACE-IT system for repairs. The program manager will be responsible for tracking all facility repairs and damage to the physical plant, as well as the progress of those repairs. Property damage when caused by clients must include an incident report and possibly a report through the IRIS system depending on the nature of the incident.	4/23/22

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V 736	Continued From page 43 -upper outer pane of the window was broken; -no access from inside the bedroom; -outside broken pane covered with cardboard; -no access from outside. Interview on 3/22/22 with the Team Lead #2 revealed: -maintenance had to measure the window pane and order a replacement; -when the replacement window pane comes, it will be replaced.	V 736		
V 752	27G .0304(b)(4) Hot Water Temperatures 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit. This Rule is not met as evidenced by: Based on record review, observations and interview, the facility failed to ensure in areas of the facility where clients were exposed to hot water, the temperature of the water was maintained between 100-116 degrees Fahrenheit. The findings are: Observations on 3/22/22 at 2:50pm revealed: -hot water temperature in the kitchen sink was 122 degrees Fahrenheit; -hot water in the female clients' bathroom sink was 129 degrees Fahrenheit.	V 752	The former program manager did not utilize the environmental checklists or environmental/physical plant standards to maintain awareness of water temperatures. This includes the "Lead BHC" duty list and training on aspects of the physical plant. The request was made to turn down the temperature of the hot water heater for the facility to bring the temperatures in compliance. The process was re-implemented and the shift leads were given duty checklists to record and maintain water, refrigerator/freezer, and thermostat temperatures. There remain no incident reports that note or document client injury or adverse reaction to the facility's hot water. Temperature logs are housed in the Program Manager's office.	5/15/22

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V 752	Continued From page 44 Interview on 3/22/22 with the Team Lead #2 revealed he was not aware the hot water temperatures were too hot. Review on 3/18/22 of the facility incident reports from 1/1/22-3/18/22 revealed no documentation of any injuries as a result of the hot water temperatures.	V 752		