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V 000	INITIAL COMMENTS A compliant survey was completed on 05/12/2022. The complaints were unsubstantiated (Intake #NC00187095, #00187100, #00187321) and a complaint was substantiated (Intake #NC00187890). The facility is licensed for the follow service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents. The facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 6 current clients and 1 former client.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and	V 108	RECEIVED JUN 13 2022 DHSR-MH Licensure Sect	

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V 108	Continued From page 1 trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure training in Cardiopulmonary Resuscitation (CPR) and First Aid, training in infectious diseases and bloodborne pathogens and training to meet the MH/DD/SA needs of the client as specified in the treatment/habilitation for 1 of 6 Staff (#4). The findings are: Review on 04/25/2022 of Staff #4's record revealed: -Hire date of 01/13/2022. -Job Title of Residential Care Specialist. -No documentation of completion for CPR and First Aid Training, Bloodborne Pathogens, or MH/DD/SAS/Client Specific Training. Attempted interview on 04/29/2022 with Staff #4 was unsuccessful due to disconnected phone line. Interview on 05/03/2022 with the Program Director/Qualified Professional (QP) revealed: -Training department responsible for scheduling	V 108	V108- **Correction**: 1. All current Residential Care Specialists (RCS) Staff in Yorke Cottage who have not been trained in CPR & First Aide, Bloodborne Pathogens, or Client Specific Training will be trained within 60 days of exit. **Prevention**: 1. All new RCS staff will be required to attend CPR training, Bloodborne pathogens, and client specific training during the New Employee Orientation period. **Monitoring:** 1. Program Supervisors will register all current RCS staff and send the Program Director a monthly update of all training completions	By 7/11/22 Effective: 7/1/22 Effective: 6/15/22

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V 108	Continued From page 2 staff trainings. -"It's the training department. They (staff) go through TCI (Therapeutic Crisis Intervention) and then they (staff) hit the floor. They (staff) shadow other staff." -"I will let the staff know about Relias trainings." Interview on 04/26/2022 with Quality Improvement Specialist (QIS) revealed: -"Yes, I can give you my stuff (information pertaining to internal investigations), but I have to wait for HR (Human Resources) to send me information." Attempted interviews on 04/25/2022 and 04/26/2022 with the Residential Director was unsuccessful due to missed return call from Residential Director on 04/25/2022. Surveyor returned Residential Director's call, left voice message and followed up with text message on 04/25/2022. No response received. Voice message left on 04/26/2022. No response received.	V 108	V512 **Correction**: 1. All RCS staff transitioned to the same TCI refresher rotation which will ensure that staff from programs and teams will be trained at the same time improving team competency, communication and accountability practices. Refreshers are pre scheduled for the year with next sessions occurring 7/19 & 7/21, 10/18 & 10/20, 1/17 & 1/19. 2. Staff found in violation of rule as a result of allegations were immediately terminated **Prevention:** 1. Development and implementation of a specific no escorting procedure statement in addition to the formal policy for staff review and comprehension 2. Addition of Client Rights Manual sign off for all RCS staff within initial 30 day onboarding process 3. Video review of all RI to be conducted by Program Supervisors following RI to ensure fidelity to the TCI model & Thompson Agency Policies/Procedures **Monitoring:** 1. Program Supervisors will submit monthly update on RCS compliance standing with onboarding documentation 2. RI debriefing compliance will be reviewed at monthly leadership meeting by Program Director	Effective 6/1/22 By 7/1/22 By 7/1/22
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and	V 512		

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aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter.
(e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.

This Rule is not met as evidenced by:
Based on records review and interviews, 2 of 6 Staff (#4 and #5) abused 2 of 6 Clients (#1 and #4) and 2 of 6 Staff (#3 and #6) failed to protect 2 of 6 Clients (#1 and #4) from abuse. The findings are:

Review between 03/28/2022-04/26/2022 of the Licensee's Client Right's Handbook revised 04/21/2021 revealed:
-" ... 20. TCFF (Thompson Child & Family Focus, Licensee) has a "no escorting" policy for our consumers. In this contest, escorting means grabbing/pulling by the extremities, carrying, lifting, pushing. This policy is in place to prevent potential physical and psychological harm of consumers and the potential harm to staff."

Findings #1:

Review on 05/04/2022 of Client #1's record revealed:
-Admission date of 03/07/2022.
-Diagnosed with Post Traumatic Stress Disorder (PTSD)-Unspecified, Reactive Attachment Disorder, Disruptive Mood Dysregulation Disorder

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and Attention-Deficit/Hyperactivity Disorder.
-Age 12.

Review on 04/27/2022 of Staff #3's record revealed:
-Hire date of 11/02/2020.
-Job title of Residential Care Specialist (RCS).
-Therapeutic Crisis Intervention (TCI) Training date 01/07/2022 and 04/21/2022.
-Reporting Suspected Abuse, Neglect or Exploitation Policy Training date 02/28/2021.

Review on 04/25/2022 of Staff #4's record revealed:
-Hire date of 01/13/2022.
-Termination date 04/06/2022.
-Job title of Residential Care Specialist (RCS).
-TCI Training date 01/14/2022.

Review on 04/29/2022 of the facility's video surveillance for incident dated 04/02/2022 revealed:
-Yorke Camera 3; 4 minutes of video footage from 11:29 am to 11:33 am.
-Staff #4 seated in a red chair in the middle of the floor on his (Staff #4) phone.
-Client #1's bedroom door closed. Client #1 opened his bedroom door and slowly walked out in the common area with his (Client #1) arms crossed.
-Client #1 looked at Staff #4, continued to walk and avoid Staff #4.
-Staff #4 got up from the chair and placed his phone in his pants pocket in a swift move. Extended his (Staff #4) left arm and placed it on Client #1's chest area slightly above his (Client #1) crossed arms.
-Staff #4 with a swift forced motion (walked fast) began to escort Client #1 (seen walking backwards) to his bedroom, still with his (Staff #4)

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V 512	Continued From page 5 hand on Client 1's chest. -Near the entrance to the bedroom door, Staff #4 placed both hands on Client #1's shoulders and with force placed him (Client #1) inside the bedroom. Bedroom light turned on. -Staff #4 began to pick up items (unknown) off the floor and placed them (items) outside of the bedroom door. -Staff #4 stood up and engaged in conversation with Client #1 (who was not in camera view) for a few seconds. Staff #4 then resumed picking up items off Client #1's bedroom floor. Staff #4 stood in the doorway and looked at his phone for a few seconds. Staff #4 attempted to close the bedroom door but Client #1 intervened. Staff #4 began to forcefully pull the door from Client #1's grasp and after a few forceful pulls succeeded in closing the bedroom door, he (Staff #4) stood and held the door closed. Client #1 attempted to open the door and Staff #4 quickly and forcefully pulled and held the door closed. Power struggle with the door continued for a few seconds. -Staff #4 looked up for a second and then looked down at his phone. Power struggle with door continued. He put his phone in his pocket, opened the door and stormed into Client #1's bedroom. Staff #4 and Client #1 were face to face and Staff #4 extended his arms and appeared to grab and lift Client #1. Client #1's foot hung off the bed and moved. -Client #1's bed was against the wall and could be seen moving. Staff #4 and Client #1 was out of the camera's view for 5-10 seconds. -Staff #4 re-emerged in camera's view and flung Client #1's mattress outside the room. -Client #1 never came back into camera's view. -Footage ends with mattress outside bedroom door and staff bent over gathering items off Client #1's bedroom floor. -No additional footage provided.	V 512		

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V 512	Continued From page 6 -Extended footage to include at least 10 minutes before and after the incident was verbally requested from Quality Improvement Specialist (QIS) on 04/26/2022. Extended footage was not received by survey exit. Review between 04/27/2022-05/10/2022 of the facility's Incident Report for Client #1 revealed: -"Completed by Residential Director. -Provider learned of incident on 04/06/2022. -Incident includes allegation against staff. -Physical Abuse box checked." -Describe the cause of this incident: 04/05/2022. [Client #1] had an emotional outburst following an activity that he did not want to participate in. [Client #1] reported that while he was struggling with behaviors, a staff member (Staff #4) placed his (Staff #4) arm across his (Client #1) chest/neck area and held him (Client #1) against the wall. -Incident Prevention: 04/05/2022. Employee was up to date in training expectations and had recently signed off on numerous documents related to client rights, boundaries, therapeutic environment, and employment expectations." Review between 04/27/2022-05/10/2022 of a document titled Investigation Report dated 04/02/2022 and completed by QIS revealed: -" ...Date: 4/05/2022. -RE: Allegation of Abuse. -The Complaint/Allegations; Date: 04/04/2022. -Incident (s): Program Director called QIS to report an allegation of abuse that had occurred over the weekend. Program Director stated that nurse sent an email alleging that the consumer disclosed that a staff member placed his arm on his mouth and pressed him against the wall in his bedroom. -Evidence/Documents Reviewed Camera footage	V 512		

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V 512	Continued From page 7 was reviewed on the [Video Monitoring System] (Yorke 3) for Saturday 4/2/2022 (11:29a-11:33a), Training Transcript reviewed for [Staff #4], HR (Human Resource) review of staff documentation for staff [Staff #4] and 7a-7p shift note. -Date/Time the Investigation Was Completed: 04/05/2022. -Conclusions: Based on interviews with the client and staff the evidence supports that staff was utilizing a protective intervention. Both parties involved described a technique to release the pressure from a bite known as "feed the bite" and the technique is not outside of the scope of staff's training using TCI (Therapeutic Crisis Intervention) techniques. Upon review of the camera, footage does not show staff pressing his arm into the client's mouth; however, footage did show actions that are against best practice and company policy. As a result of staff not adhering to policies and procedures outlined in client rights documentation, therapeutic environment and boundaries, and employee expectations the staff member will be terminated from his position as Residential Care Specialist. -Date/Time the Investigation Was Completed: 04/05/2022." -No witness statements from Staff #3, Clients #1, #2, #3, #4, #5, or #6. -No completion of root cause analysis. Review on 04/29/2022 of Emailed Correspondence dated 04/05/2022 from Staff #4 to the QIS revealed: -"RE: Witness Statements. -After getting into a physical fight with [Client #6], [Client #1] was directed to take space in room. After being in his room for a few minutes [Client #1] walked out and shouted at me (Staff #4) that he was leaving and wasn't going to listen to me. I was able to get [Client #1] back to his room.	V 512		

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[Client #1] was visibly escalated and began to scream and told me he wanted to stab me. [Client #1] then began to get physically aggressive with me. I gave him (Client #1) several directives to stop and tried to talk him through his aggression but he continued. [Client #1] continued attack me and he then bit me (Staff #4) which I then did as I was trained to do and feed the bite which he bit harder at first but then he stopped biting me. He proceeded to try to attack me myself and [Staff #3] both tried to talk to [Client #1] to help get him back to baseline but he contribute to try to attack me and scream. After several more minutes of [Client #1] being aggressive I was finally able to make progress with him and help get him (Client #1) back to his baseline behavior there were no further issues from [Client #1]."

Review on 04/29/2022 of document titled Service Note dated 04/02/2022 completed by Staff #3 on 04/03/2022 revealed:
-"Intervention Outcome: Client (Client #1) seemed irritated all morning because he felt like he didn't get enough sleep and took it out on his peers as well as staff. Client got into an altercation dealing with a peer because he kicked him in the back. Staff had to remove client from situation and brought him back in the cottage. While back in the cottage client (Client #1) kept attempting to punch/ bite staff and staff kept trying to deescalate."

Interview on 05/03/2022 with Client #1 revealed:
-"I (Client #1) can tell you a little bit. For 2 weeks, [Client #6] tried to kill me like choke me out. I was on the ground and he (Client #6) came behind me and put his arm around my neck. [Staff #3] told him (Client #6) that he was not doing it right and grabbed him off me. Then one day he (Client #6) started to try to fight me outside and I was like I

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am sick of him (Client #6) hitting me. I started fighting him. [Staff #4] comes get me (Client #1) and takes me inside and restrained me after [Client #6] had been attacking me . [Client #6] and [Staff #4] play favorites with each other. [Staff #4] was dragging and trash talking me. I wasn't crying but it hurt like crap. He (Staff #4) had me against the wall with his arm against my mouth. I pinched him and he (Staff #4) stopped. I told him that since he didn't let me go, I (Client #1) was going to fight back. He pushed me on the ground and started pushing my pressure points. He (Staff #4) was still applying pressure to my hand and I did start crying. He was applying pressure and telling me to stop crying. How was I to stop crying when he was applying pressure. He was like I don't care, stop crying and then I called [Staff #3]. She (Staff #3) was telling him (Staff #4) to stop applying pressure and let go. I forced myself to stop crying and then he let go. [Staff #3] came by my door occasionally and saw what was happening. She (Staff #3) knows the story, because she was there."

Interview on 05/03/2022 with Client #2 revealed:
-"You (surveyor) have to ask somebody else. Do you have the right person to talk to? I (Client #2) don't know what happened."

Interview on 05/03/2022 with Client #4 revealed:
-Did not witness the incident.
-"I don't exactly know what happened. But, [Staff #4] was abusing him (Client #1)."
-Client #4 did not specify why he felt Staff #4 was abusing Client #1.

Interview on 05/03/2022 with Client #5 revealed:
-"[Client #1] was beating on [Staff #4] and [Staff #4] pushed him out of the way. He (Staff #4) took all his (Client #1) stuff out his room and left him in

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the dark. [Staff #4] was holding the door."

Interview on 05/03/2022 with Client #6 revealed:
-"[Client #1] started punching [Staff #4]. [Staff #4] pushed [Client #1] to the ground and [Staff #4] was on top of [Client #1]. I am pretty sure. I (Client #6) don't know anything else that happened. Three people said that [Staff #4] choked [Client #1]. It was [Client #5] and [Former Client #7]. That's all I know."

Attempted interview on 04/29/2022 with Staff #4 was unsuccessful due to disconnected phone line.

Interview on 05/06/2022 with Staff #3 revealed:
-"I can't remember what time the incident happened. I think it was in the afternoon around 2 or 3. I can't remember the exact time. We came back in from the outside."
-"Actually, it happened in the fenced in (fenced area outside in back of the cottage), [Client #1] got into it with one of the peers and [Staff #4] decided to take him (Client #1) inside because he would not calm down and kept trying to get at his peer. By the time I (Staff #3) came in, [Staff #4] was standing at the door because [Client #1] kept trying to come out. [Client #1] was saying why yall trying to keep me in my room and [Staff #4] said because you keep trying to fight your peer. That's when he (Client #1) started to fight [Staff #4], he bit him and kneed him (Staff #4) in his private area. [Staff #4] was trying to push [Client #1] off him. [Client #1] was really upset and he (Staff #4) was not calming him down. [Client #1] kept putting hands on him (Staff #4)."
-Staff #4 and Client #1 were alone in the facility. "Like 30 minutes. A good 30 minutes."
-"At one point, I (Staff #3) did say leave him (Client #1) be because [Client #1] was so upset.

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V 512	Continued From page 11 -"I don't remember seeing a chair in the middle of the floor. A couple of times when I (Staff #3) came out of the kitchen they (Staff #4 and Client #1) were in the room; slash inside and out the room from what I remember." -"Basically, the policy is you (staff) have to stand outside the client's door in the line of sight of the camera. Staff is not supposed to go in the room alone unless another co-worker is present." Interview on 05/10/2022 with the facility's TCI Instructor while reviewing video footage of the 04/02/2022 incident revealed: -"That's (escorting client backwards to his room) not a TCI technique." -Client #1's bedroom door held closed and room confinement was not an approved intervention. "We don't teach seclusion. Like keeping the kid somewhere against his will." -In response to bed moving, "We are not supposed to restrain on soft surfaces. Restraints should be done on the floor." Findings #2: Review on 05/06/2022 of Client #4's record revealed: -Admission date of 03/07/2022. -Diagnosed with Unspecified Disruptive, Impulse Control, and Conduct disorder, Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive/Impulsive presentation. -Age 11. Review on 05/06/2022 of Staff #5's record revealed: -Hire date of 09/20/2021. -Termination date 04/19/2022. -Job title of RCS.	V 512		

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	MHL0601171	A. BUILDING: _____ B. WING _____	C 05/12/2022

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V 512	Continued From page 12 -TCI Training date 01/07/2022. Review on 05/06/2022 of Staff #6's record revealed: -Hire date of 11/30/2020. -Job title of Residential Care Specialist (RCS). -TCI Training date 05/20/2021. -Reporting Suspected Abuse, Neglect or Exploitation Policy Training date 02/18/2022. Review on 05/06/2022 of the facility's video surveillance for incident dated 04/13/2022 revealed: -Yorke Camera 1; 20 minutes of video footage from 9:13 pm to 9:32 pm. -Dining area; Staff #5 and Staff #6 emerge in view of the camera. -Client #4 came into view and immediately began to display disruptive behavior; jumped on dining table seat, stood against wall and engaged in conversation with Staff #6, while Staff #5 was seated at dining table. Staff #6 went in kitchen door. Client #4 attempted to go in behind her. Staff #6 came out of the kitchen and took a seat at the table. Client #4 came back in view and jumped on the table. Staff #6 got up from the table and walked to front door. Client #4 followed her. Staff #6 attempted to enter office door and Client #4 began to interfere. Client #4 pushed Staff #6 and moved back. Client #4 walked back to dining area and moved out of camera view. Staff #6 came out of the office area and sat at table. Client #4 came back into view and invaded Staff #'s 6 personal space and wiggled an item in her face. -Client #4 walked back to office door and kicked it. He walked back into the dining area and attempted to get the mop and bucket. Staff #6 attempted to intervene, blocked Client #4 from getting the mop and attempted to enter kitchen	V 512		

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V 512	Continued From page 13 door. Client #4 continued attempts for the mop. Staff #5 came into camera view and with his hand opened slapped Client #4 on the back and then pushed him to the ground. Client #4 stood up and Staff #5 grabbed his hands and escorted Client #4 (walking backwards) out of the dining area. Staff #6 placed the mop bucket in kitchen, came back in view and sat at dining table. Client #4 or Staff #5 could no longer be seen. After a few seconds, Staff #6 got up from the table and moved out of view of camera. -Extended footage to include at least 10 minutes before and after the incident requested via email to the QIS on 05/06/2022. Footage received included scene of dining table from 9:25 pm - 9:32 pm, when the evidence above supports that the incident had carried over from dining area to the Client's bedroom. Review between 05/06/2022-05/10/2022 of the facility's Incident Report for Client #4 revealed: -"Completed by Residential Director. -Provider learned of incident on 04/15/2022. -Incident includes allegation against facility. -Physical Abuse box checked. -Describe the cause of this incident: 4/16/2022 Client was up engaging in moderate behaviors/dysregulation and reported that a staff (Staff #5) member engaged with him in a physically aggressive manner. -Incident Prevention 4/16/2022 Staff member was up to date in all trainings, including de-escalation training. 4 total supervisors were physically present on campus during the timeframe of the incident and the staff member in question did not utilize the on call system to request any additional support for he and his team while client was displaying behaviors." Review between 05/06/2022-05/10/2022 of a	V 512		

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V 512	Continued From page 14 document titled Investigation Report dated 04/18/2022 and completed by the Quality Improvement Specialist (QIS) revealed: -"Date: 4/18/2022. -RE: Allegation of Abuse. -The Complaint/Allegations; Date: 04/14/2022. -Incident (s): Program Director [Residential Director] called QIS on 04/14 to report that a supervisor had sent a photo of bruising on client [Client #4] and was informed that the client reported that a staff member had 'Hulk Smashed' him on 04/13. -Evidence/Documents: Camera Footage was viewed on [Video Monitoring System] for evening of 4.13 (9:24 -9:27pm), HR (Human Resources) review for both staff present([Staff #5] and [Staff #6]), Training transcripts for staff member [Staff #5] and [Staff #6 and Reviewed shift notes for 4.13 and 4.14. -Conclusions: During staff interviews both staff members reported that the client became disruptive because no one was seated at his door. Staff reported redirecting the client back to his room after he became assaultive toward the female staff member attempting to get the mop and bucket as well as calling her derogatory names. The staff deny witnessing or engaging in actions that could be viewed as abusive. During interview with the client, he reported that he was behaving in a disruptive manner and also reported that staff dragged him to his room and slapped him while in his room because he would not go to bed. Review of the camera shows staff engaging client in a physically aggressive manner. As a result of evidence viewed on video and the report of the client the allegation of abuse is validated. -Date/Time the Investigation Was Completed: 04/15/2022." -Staff #5 or #6 did not report the incident.	V 512		

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V 512	Continued From page 15 Review on 05/06/2022 of Emailed Correspondence dated 04/20/2022 from Staff #6 to the QIS revealed: -"RE: Witness Statement. -On of the boys went AWOL. He was trying to attack me. He attempted to take the mop but Coker filled with water away from me so that he could pour the water on me and hit he with the bucket. He was smacked my coworker in his face multiple times. The adolescent was uncooperative every time we attempted to redirect him. My coworker attempted to escort him in his room so that he wouldn't wake the rest of the boys in the cottage. He then became even more irate and began flipping over his bed the actual wooden portion of his bed. My coworker sat by his door and eventually able to D escalate the situation." Review on 05/06/2022 of document titled Service Note dated 04/13/2022 completed by Staff on 04/17/2022 revealed: -"Date of Service: 04/13/2022 - 07:00 PM. -Service Duration: 720 minutes. -Intervention Activity: [Client #4] processed with staff several times. [Client #4] had been redirected a few times and received a PRN. [Client #4] eventually went to sleep. [Client #4] slept thru the night and did not wake. Staff checked on [Client #4] often. Staff disinfected the cottage, washed clothes, and wiped down the door knobs. -Intervention Outcome: [Client #4] remained asleep upon the arrival of first shift." -Service Note not completed by Staff #5 or #6. -Service Note completed by a person not listed on the Internal Investigative report as witness or being present during incident.	V 512		

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V 512	Continued From page 16 Interview on 05/03/2022 with Client #4 revealed: -"I had an incident with [Staff #5] about a week or 2 ago. He was hitting on me. He is gone now. He (Staff #5) threw me in my room and slapped me. I (Client #4) slapped him (Staff #5) back and he started abusing me. I told everyone about it; my therapist, supervisors and next level higher up people. I told my guardian. He (Staff #5) was fired and [Staff #4] is fired too." Interview on 05/10/2022 with Client #5 revealed: -"[Staff #5] slapped/smacked [Client #4]." -"In [Client #4]'s room." -Was in the doorway when incident between Staff #5 and Client #4 occurred. Interview on 05/09/2022 with Staff #5 revealed: -Served as RCS. -Started position around Sept 2021. -"It happened about 10-11 pm that night. There was a lot of things happening, police were there, 2 police were in Yorke when I got there. I heard that 2 of the kids had issues and they (police) were called. Many of the kids were having behaviors. Kids had gotten their medications and everybody had transitioned to bed but [Client #4] and other client. He (Client #4) had requested for me to sit by the door until he went to sleep and I did but he would not go to sleep. I told him that I had to work. He had asked for milk and a snack and we gave him everything. I told him (Client #4) to go to bed, we had a discussion and he began to yell. He tried to attack the female staff (Staff #6) I was working with and I told him (Client #4) that he can't attack the female staff. We had 2 options, which was put him (Client #4) in a restraint or let him keep doing what he was doing. I grabbed his hand and walked him to his room. I was standing by his (Client #4) door and he raised his hand and he slapped me. I told him it	V 512		

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was wrong and he can't be slapping me (Staff #5). I pulled his hands off of me and closed the door. He (Client #4) started saying he didn't want to be here. He kept on and pulled his bed down. He came back outside and ran inside the room. He said I (Staff #5) slapped him, but I did not slap him. I removed his hands from the door. They terminated me on the 19th (April). I went back to the work on the (April) 14th and they (Licensee Representative) said that I had to go back home for the investigation. They [QIS] and [SA-Program Director/QP] notified me that I was terminated on the 19th of April."
-"I (Staff #5) did not slap [Client #4], I (Staff #5) just moved his (Client #4) hands.
-"There is a lot of things going on and the program needs to be more interactive."

Attempted Interview on 05/10/2022 with Staff #6 was unsuccessful due to no response to voice or text message from Surveyor.

Interview on 05/10/2022 with the Program Supervisor/Qualified Professional revealed:
-"I was coming out the kitchen and [Client #4] was telling the therapist that [Staff #4] 'hulk smashed' him (Client #4) on the back. The therapist saw something on his (Client #4) neck and asked him (Client #4) what it was and he said I don't know and left and went into the bathroom and came back and said [Staff #4] did that.
-"I called [Staff #4], he was put on leave and I reported it (the allegation) to our Director of Compliance, they did due diligences and he (Staff #4) was fired."
-"They interviewed staff and pulled cameras."
-"I have no idea (if clients were interviewed). I know for a fact she (QIS) talked to [Client #4]. She (QIS) did her investigation work."

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V 512	Continued From page 18 Interview on 05/10/2022 with the facility's TCI Instructor while reviewing video footage of the 04/13/2022 incident revealed: -"Looks like he (Staff #5) just pushed the kid (Client #4). From what I saw nothing was TCI." Interview on 05/10/2022 with the Chief Performance and Quality Officer revealed: -"Wait, what I am confused. I thought [Residential Director] told you about all the things we have been doing. We have been retraining staff." -Questioned Surveyor about survey entrance date. Responded, "And you are still here?" -"So, you mean to tell me we did all of this for nothing." Review on 05/11/2022 of the Plan of Protection (POP) dated and signed by the Chief Performance and Quality Officer on 05/11/2022 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? -4/2/2022 Incident - Staff member was immediately put on administrative leave and after internal investigation was completed staff was terminated on 4/6/2022. -4/13/2022 Incident - Staff member was immediately put on administrative leave and after internal investigation was completed staff was terminated on 4/19/2022. -4/19/2022 and 4/21/2022 - TCI Refresher Trainings (in person 3-hour trainings) completed for staff on TCI Modules - Assessing a Crisis Situation, Safety Interventions, and Practicing Protective Interventions & Restraints with Resistance. (Documentation of agenda and sign in sheets attached ...all direct care staff were required to attend these trainings. 50 staff completed the trainings). -3/24/2022 - Director and Performance Quality	V 512		

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V 512	Continued From page 19 Improvement (PQI) provided training to Residential Supervisors on Allegations of Abuse (sign in sheet attached) -3/25/2022 - Email from PRTF Director of Client Rights Manual and education of clients rights and prohibited behaviors sent to all residential staff. (attached) -3/30/2022 - Email to all residential staff from VP of Residential services regarding concerns of recent allegations of abuse (attached) -4/2/2022 - 4/14/2022 - Client Rights Manual acknowledgement sent out to all residential staff to sign and acknowledge via DocuSign (attached). -4/25/2022 - Residential Incident Reporting Operating Guidelines/protocols reviewed and updated by Residential Leadership. (attached) -5/2/2022 - Directors provided training to Residential Supervisors on Incident Reporting protocols -Program Supervisors will have Boundaries Guide and Code of Ethics reviewed/re-signed off on by all RCS staff in their individual supervisions by 5/31/2022. -Learning & Development Specialist will re-assign the Client Rights training in Relias to Yorke staff with a completion date for everyone by 5/31/2022. -PRTF Director will re-post the compliance hotline # in Microsoft Teams channel so that staff are more clear on avenues to report abuse or concerns by 5/16/2022. -PRTF Director will email residential staff information about Thompson's Employee Assistance Program (employee benefit) by 5/16/2022 for counseling resources. -Describe your plans to make sure the above happens. -Some Actions have already been completed including termination of staff, training, communication to staff/emails, updated protocols.	V 512		

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V 512	Continued From page 20 Evidence attached. -During weekly residential leadership meeting will review POP to ensure remaining actions are completed by deadline. If actions are not taken by the deadline, appropriate employee coaching and progressive discipline policy will be utilized." Client #1 was 12 years old and diagnosed with PTSD-Unspecified, Reactive Attachment Disorder, Disruptive Mood Dysregulation Disorder and Attention-Deficit/Hyperactivity Disorder. He had a history with challenges in regulating his emotions, anger management, authority and interpersonal relationships. Staff #4 was trained in TCI and failed to utilize approved interventions when he (Staff #4) engaged Client #1. Client #1 was abused by Staff #4. Client #4 was 11 years old and diagnosed with Unspecified Disruptive, Impulse Control, Conduct disorder, and Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive/Impulsive presentation. He had a history of physically and verbally aggressive behaviors with destruction of property, lack of remorse, initiated fights, manipulated others, bullied/threatened others, deliberately annoyed others, and blamed others. Staff #5 was trained in TCI and failed to utilize approved interventions when he (Staff #5) engaged Client #4. Client #4 was abused by Staff #5. Staff #3 and #6 were also trained in TCI. Staff #3 witnessed the 04/02/2022 incident with Client #1 and Staff #4 and Staff #6 witnessed the 04/13/2022 incident with Client #4 and Staff #5. Neither Staff #3 or #6 intervened to protect Clients #1 or #4. In addition, Staff #3 and #6 were trained in the Licensee's Policy for Reporting Suspected Abuse, Neglect or Exploitation Policy and both failed to report the incidents witnessed. The Licensee failed to provide surveillance footage of the incidents on 04/02/2022 and	V 512		

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V 512	Continued From page 21 04/13/2022 in entirety when evidence suggested both incidents persisted beyond the footage provided. This deficiency constitutes a Type A1 rule violation for serious abuse and must be corrected within 23 days. An administrative penalty of $ 2000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 512		