Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601172	A. BUILDING: _____ B. WING _____	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHIN COTTAGE	6750 SAINT PETERS LANE, SUITE 400 MATTHEWS, NC 28105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and complaint survey was completed on 06/17/2022. The complaint was substantiated (Intake #NC00186725). Deficiencies were cited. 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 3. The survey sample consisted of audits of 3 current clients.	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 trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross,	V 108	V 108- **Correction:** 1. All current Residential Care Specialist (RCS) staff who have not been trained will be trained in CPR and First Aide, Bloodborne Pathogens, or Client Specific Training. **Prevention:**1. All new RCS staff will be required to attend CPR and First Aide, Boodborne Pathogens, or 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 8/15/2022 Effective 7/1/2022 Effective 7/1/2022

Division of Health Service Regulation

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

Hannah Dunham, LCSW Chief Performance & Quality Officer 6/30/2022

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V 108	Continued From page 1 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 for 2 of 11 Staff (#7and the Qualified Professional (QP)), 1 of 1 Former Staff (FS #10), training in infectious diseases and bloodborne pathogens for 1 of 1 Former Staff (FS #10). The findings are: Review on 04/26/2022 of Staff #7's record revealed: -Hire date of 10/18/2021. -Job Title of Residential Care Specialist (RCS). -No documentation of completion for CPR and First Aid Training. Review on 03/23/2022 of FS #10's record revealed: -Hire date of 10/04/2021. -Job Title of RCS. -No documentation of completion for CPR and First Aid Training and Bloodborne Pathogens. Review on 03/23/2022 of the Qualified Professional (QP)'s record revealed: -Hire date of 07/12/2021.	V 108		

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V 108	Continued From page 2 -Job Title of QP. -No documentation of completion for CPR and First Aid Training. Review between 03/21/2022-03/23/2022 of a document titled Investigation Report dated 02/07/2022 and completed by the QIS revealed: -Staff #7 and FS #10 were the only staff present at the facility during the time of the 02/03/2022 incident. Interview on 04/28/2022 with Staff #7 revealed: -All trainings were up to date. Attempted interview on 04/21/2022 with FS #10 was unsuccessful due to no answer to phone call, voice message, or text message. Interview on 03/28/2022 with the QP revealed: -Was not the QP. -Served as RCS. -"I am not the QP at Thompson (Licensee). I have the credentials for QP but again am not serving in that capacity at Thompson (Licensee)." -"I am update on my trainings." -"TCI (Therapeutic Crisis Intervention), CARE training, CPR/First Aid. I think those were all I had in the beginning. The others were on [training module]." Interview on 04/20/2022 and 05/03/2022 with the Program Supervisor revealed: -Was the QP. -Training department responsible for scheduling 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 [training module]	V 108		

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V 108	Continued From page 3 trainings. Interview on 03/23/2022 and 04/26/2022 with the Quality Improvement Specialist (QIS) revealed: -"They (HR) don't have the information you requested for them (Staff #1 and QP)." -"Yes, I can give you my stuff, but I have to wait for HR (Human Resources) to send me information (Staff trainings, HCPR checks, Background checks, and etc.)."	V 108		
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 fire and disaster drills were conducted quarterly and repeated on each shift. The findings are: Review on 03/23/2022 of the facility's fire and	V 114		

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V 114	Continued From page 4 disaster drill log from 03/31/2021- 02/25/2022. -No documentation of 1st shift fire or disaster drills for 4th quarter from December 2021-February 2022. -No documentation of 3rd shift fire or disaster drills for 4th quarter from December 2021-February 2022. Interview on 03/28/2022 with Client #1 revealed: -"Yes, I go outside the building and go to a tree and that's it." Attempted interview on 03/28/2022 with Client #2 was unsuccessful due to the client no longer wanted to talk. Interview on 03/28/2022 with Client #3 revealed: -Did 10 or 12 drills. -Go outside in the grass (during fire drill). -"You put your head between your legs and get against the wall." Interview on 04/20/2022 with the Program Supervisor revealed: -"Facility maintenance does the fire and disaster drills. I am not aware of missing drills." Interview on 04/20/2022 with the Residential Director revealed: -"Facilities set the drills off and we conduct the drill. I am not sure why drills were missed, but we did have a few COVID cases at facilities."	V 114	V 114 **Correction:** 1.Drill log was reviewed with Chief Facilities Officer and it was noted that drills were not conducted in December due to an outbreak of COVID-19 in the facility. Chief Facilities Officer stated that this would be noted in the log for review. Drills that were completed and not in the book will be added and Chief Facilities Officer will ensure that logs are placed in book upon completion to ensure they are current and ready for review. Additionally as of February 2022 the facility operates on a 12 hour shift schedule thus only two shifts are noted for drills. **Prevention:** 1. Chief Facilities Officer will review drill logs monthly and ensure that drills are completed or noted if unable to be completed as planned and ensure that this is noted in the log. **Monitoring:** 1. Chief Facilities Officer will monitor team to ensure drills are completed and documentation is placed in the log book in accordance to DHSR regulations monthly. 2. PQI Department will complete internal reviews of the drills for compliance with standards at least biannually.	Effective Immediately 6/30/2022 Effective Immediately monthly Effective Immediately
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY	V 131		

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V 131	Continued From page 5 (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. This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure the Health Care Personnel Registry (HCPR) was accessed prior to hire for 6 of 11 Staff (#1, #3, #4, #7, and #8) and 1of 1 Former Staff (FS #10). The findings are: Review on 03/23/2022 of Staff #1's personnel record revealed: -Hire date of 10/05/2020. -Job title of Residential Care Specialist (RCS). -No HCPR check. Review on 03/25/2022 of Staff #3's personnel record revealed: -No date of hire. -Job title of Residential Care Specialist (RCS). No HCPR check. Review on 03/25/2022 of Staff #4's personnel record revealed: -No date of hire. -Job title of RCS. No HCPR check. Review on 04/26/2022 of Staff #7's personnel record revealed: -Hire date of 10/18/2021.	V 131	V 131 **Correction:** 1. Current staff identified that did not have HCPR check on file will be run and placed in HR file by People Operations staff. **Prevention:** 1. People Operations team will be re-trained on standards of compliance with HCPR checks being conducted pre-hire separately from the registry checks from the back ground check vendor including reviewing process for saving the documentation to the HR file. 2. People Operations Manager will review and update pre-employment process/operating guideline to ensure specific process for HCPR checks are outlined. Monitoring: 1. People Operations Coordinator will conduct audit of HR file compliance for background checks for residential monthly and update files accordingly. PO Coordinator will report findings of HR file compliance audits to People Operations Manager quarterly. 2. PQI Department will conduct at least biannual internal reviews of select HR files in residential to ensure HCPR checks are completed pre hire for staff.	7/30/2022 7/30/2022 7/30/2022

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V 131	Continued From page 6 -Job title of RCS. -No HCPR check. Review on 04/26/2022 of Staff #8's personnel record revealed: -No date of hire. -Job title of RCS. -No documentation that HCPR was accessed. Review on 03/23/2022 of FS #10's personnel record revealed: -Hire date of 10/04/2021. -Job Title of RCS. -No documentation that HCPR was accessed. Interview on 03/28/2022 with Staff #1 revealed: -Employed since October 2020. Interview on 04/28/2022 with Staff #7 revealed: -Employed since 2021. Interview on 03/23/2022 and 04/26/2022 with Quality Improvement Specialist (QIS) revealed: -"They (HR) don't have the information you requested for them (Staff #1 and QP)." -"Yes, I can give you my stuff, but I have to wait for HR (Human Resources) to send me information (Staff trainings, HCPR checks, Background checks, and etc.)."	V 131		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to	V 132		

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V 132	Continued From page 7 any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.	V 132	V 132 **Correction:** 1. All supervisors and individuals responsible for incident reporting have been retrained on incident reporting guidelines and the necessary steps needed to ensure that all entities including but not limited to HCPR, DSS, DHSR, and LME are notified as appropriate for incidents that may occur in the facility. **Prevention:** 1. Development and Implementation of incident report guidelines to ensure process for reporting incidents is clear and was reviewed with supervisors and staff to ensure comprehension and understanding. **Monitoring:** 1. Program Supervisors will review all Level II incidents to ensure that all components of the report have been completed to include prevention/mitigation and notification oflegal guardians, LME, and other authorities required by law. 2. Program Directors will monitor adherence to the Incident Reporting Guidelines. Additionally, the Performance and Quality Improvement Department will conduct regular internal reviews of incidents to ensure compliance.	Effective 5/2/2022 Effective 5/2/2022 Effective 5/2/2022

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V 132	Continued From page 8 This Rule is not met as evidenced by: Based on records reviews and interviews, the facility failed to ensure that the Health Care Personnel Registry (HCPR) Department was notified of all allegations against health care personnel. The findings are: Review on 03/21/2022 of the facility's record revealed: -No notification to HCPR for alleged incident dated 02/24/2022 for Client #2. -No notification to HCPR for alleged incident dated 02/03/2022 for Client #3. Review between 03/21/2022-03/23/2022 of a document titled Investigation Report dated 02/25/2022 and completed by the Quality Improvement Specialist (QIS) revealed: -"Investigative file- [Client #2] -Date: 02/25/2022. -RE: Complaint of Improper/Undocumented Restraint using excessive force. -The Complaint/Allegations; Date: 02/25/2022. -Date/Time Investigation began: 03/03/2022." -Internal Investigation substantiated allegation of abuse against Staff #3. Review between 03/21/2022-03/23/2022 of a document titled Investigation Report dated 02/07/2022 and completed by the QIS revealed: -"Investigative file- [Client #3] -Date: 02/07/2022. -RE: Incident/Allegation or Complaint Investigated. -The Complaint/Allegations; Date: 02/04/2022. -Date/Time Investigation began: 02/07/2022." -Former Staff (FS) #10 was not placed on administrative leave pending the investigation. -Internal Investigation unsubstantiated allegation	V 132		

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V 132	Continued From page 9 of abuse against Former Staff (FS) #10. Interview on 03/23/2022, 03/24/2022 and 03/28/2022 with the QIS revealed: -Did not notify HCPR department of allegation of abuse for Staff #3 or FS #10. Interview on 04/20/2022 with the Program Supervisor revealed: -Did not notify HCPR department of allegation of abuse for Staff #3 or FS #10. -"Within in the last 2 months, I was made aware of HCPR and honestly I had no clue ..." Interview on 04/20/2022 with the Residential Director revealed: -Did not notify HCPR department of allegation of abuse for Staff #3 or FS #10. -" ... I as the director do the IRIS report (HCPR section) as of Mid-March 2022." -"There is no excuse, but I (Residential Director) think that was maybe her (QIS) first internal investigation. I really have nothing to say other than what you saw was what it was." Interview on 05/05/2022 with HCPR Representative revealed: -HCPR department was not notified of allegation of Harm, Abuse, Neglect or Exploitation for Staff #3 or FS #10.	V 132		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies	V 366		

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V 366	Continued From page 10 shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team;	V 366	V 366 **Correction:**1. Residential Incident Reporting Operating Guidelines/protocols reviewed and updated by Residential Leadership (4/25/2022). 2. Residential Program Director reviewed the Incident Reporting Guidelines/protocols with Program Supervisors. 3. Quality Improvement Specialist will attend cottage staff meetings to train and review incident reporting procedures and protocols with direct care staff (Within 60 days of reopening Alphin Cottage). **Prevention:**1. Development and Implementation of incident report guidelines to ensure process for reporting incidents is clear and was reviewed with supervisors and staff to ensure comprehension and understanding. 2. Incident reporting operating guideline included in new hire training orientation. **Monitoring:** 1. Program Supervisors will review all incidents to ensure that all components of the report have been completed to include prevention/mitigation and notification of legal guadians, LME, and other authorities required by law. 2. Program Directors will monitor adherence to the Incident Reporting Guidelines. Additionally, the Performance and Quality Improvement Department will conduct regular internal reviews of incidents to ensure compliance.	Effective 5/2/2022 Effective 5/2/2022 Effective 5/2/2022

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V 366	Continued From page 11 (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if	V 366		

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ALPHIN COTTAGE	6750 SAINT PETERS LANE, SUITE 400 MATTHEWS, NC 28105

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V 366	Continued From page 12 different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement written policies governing their response to level III incidents, determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents, and submit written preliminary findings of fact to the Local Management Entity (LME)/Managed Care Organization (MCO) within five working days of the incident affecting 2 of 3 Clients (#2 and #3). The findings are: Review on 03/21/2022 of Client #2's record revealed: -No incident report for allegation of abuse incident dated 02/24/2022. -No root cause analysis for allegation of abuse incident dated 02/24/2022. -No documentation to support submission of the written preliminary findings of fact to the LME/MCO within five working days of the incident.	V 366		

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V 366	Continued From page 13 Review on 03/21/2022 of Client #3's record revealed: -No incident report for allegation of abuse incident dated 02/03/2022. -No root cause analysis for allegation of abuse incident dated 02/03/2022. -No documentation to support submission of the written preliminary findings of fact to the LME/MCO within five working days of the incident. Review on 03/21/2022 of Incident Response Improvement System (IRIS) from 10/01/2021-03/18/2022 revealed: -No level III incident report submitted for Client #2 for allegation of abuse incident dated 02/24/2022 or Client #3 for allegation of abuse incident dated 02/03/2022. Review between 03/21/2022-03/23/2022 of a document titled Investigation Report dated 02/25/2022 for Client #2 and completed by the Quality Improvement Specialist (QIS) revealed: -Substantiated allegation of abuse against Staff #3. Review between 03/21/2022-03/23/2022 of a document titled Investigation Report dated 02/07/2022 for Client #3 and completed by the QIS revealed: -Unsubstantiated allegation of abuse against FS #10. Interview on 03/23/2022, 03/24/2022 and 03/28/2022 with the QIS revealed: -Did not complete incident reports for allegations of abuse incidents dated 02/03/2022 and 02/24/2022. -Did not complete root cause analysis for allegations of abuse incident dated 02/03/2022	V 366		

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V 366	Continued From page 14 and 02/24/2022. -Did not submit the written preliminary findings of fact to the LME/MCO within five working days of the incidents. Interview on 04/20/2022 with the Program Supervisor revealed: -" ...I had no knowledge and was not trained right about the Incident Report/IRIS process..." Interview on 04/20/2022 with the Residential Director revealed: -"I am cleaning up a big mess, which I am sure you (Surveyor) can see. We are doing a complete overhaul. I (Residential Director) have been doing this for 15 years, but the system (processes) here has not caught up. I requested from my supervisor to downsize (close Alphin Cottage temporarily)."	V 366		
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 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	V 367		

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V 367	Continued From page 15 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 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	V 367	V 367 **Correction:** 1. Residential Incident Reporting Operating Guidelines/protocols reviewed and updated by Residential Leadership (4/25/2022). 2. Residential Program Director reviewed the Incident Reporting Guidelines/protocols with Program Supervisors. 3. Quality Improvement Specialist will attend cottage staff meetings to train and review incident reporting procedures and protocols with direct care staff (Within 60 days of reopening staff meetings to resume). **Prevention:** 1. Development and Implementation of incident report guidelines to ensure process for reporting incidents is clear and was reviewed with supervisors and staff to ensure comprehension and understanding. 2. Training on Incident reporting operating guideline is part of new hire orientation. **Monitoring:** 1. Program Supervisors will review all incidents to ensure that all components of the report have been completed to include prevention/mitigation and notification of legal guadians, LME, and other authorities required by law. 2. Program Directors will monitor adherence to the Incident Reporting Guidelines. Additionally, the Performance and Quality Improvement Department will conduct regular internal reviews of incidents to ensure compliance.	Effective 5/2/2022 Effective 5/2/2022 Effective 5/2/2022

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V 367	Continued From page 16 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 record reviews and interviews, the facility failed to ensure all Level III incidents were reported to the Local Management Entity (LME)/Managed Care Organization (MCO) responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident affecting 2 of 3 Clients (#2, and #3). The findings are:	V 367		

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V 367	Continued From page 17 Review on 03/21/2022 of Incident Response Improvement System (IRIS) from 10/01/2021-03/18/2022 revealed: -No level III incident reports submitted for Client #2 for allegation of abuse incident dated 02/24/2022 or Client #3 for allegation of abuse dated 02/03/2022. Review between 03/21/2022-03/23/2022 of a document titled Investigation Report dated 02/25/2022 for Client #2 and completed by the Quality Improvement Specialist (QIS) revealed: -"RE: Complaint of Improper/Undocumented Restraint using excessive force. -The Complaint/Allegations; Date: 02/25/2022." -Client #2 reported allegation of abuse against Staff #3 to the former Program Supervisor. -Former Program Supervisor reported the allegation to the Program Supervisor. -Program Supervisor reported the allegation to the QIS. -QIS reviewed footage and advised Program Supervisor to contact the Residential Director. -Residential Director reviewed information and requested a full internal investigation on 03/02/2022. -Internal Investigation substantiated allegation of abuse against Staff #3. -No level III Incident Report completed for Client #2 by any of the above Licensee representatives after becoming aware of the allegation. Review between 03/21/2022-03/23/2022 of a document titled Investigation Report dated 02/07/2022 for Client #3 and completed by the QIS revealed: -"RE: Incident/Allegation or Complaint Investigated. -The Complaint/Allegations; Date: 02/04/2022."	V 367		

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V 367	Continued From page 18 -Client #3 reported allegation of abuse against Former Staff (FS) #10 to his Therapist. -Therapist reported the allegation of abuse to the QIS. -QIS reported the allegation of abuse to the Program Supervisor. -Internal Investigation unsubstantiated the allegation of abuse against FS #10. -No level III Incident Report completed for Client #3 by any of the above Licensee representatives after becoming aware of the allegation. Interview on 03/23/2022, 03/24/2022 and 03/28/2022 with the QIS revealed: -"Still no incident report for the second incident (02/03/2022 incident for Client #3). The supervisor did not follow up with the MCO about the incident report. I need to follow up with her, she is on a conference call." -No facility incident report completed for incident dated 02/24/2022. -"To my knowledge the Incident Reporting Operating Guidelines provided is the most accurate policy." -"I (QIS) have learned that the staff are not competent in the policy (Incident Reporting). I (QIS) recognize that they (Staff) need additional training concerning the policy (Incident Reporting)." -"I (QIS) am trying to get clarification on hands on guidance by staff. But it (staff not reporting and documenting incidents) seems to be normal." -"We recognize that there is an issue with staff documenting incidents (knowing when and how)." -"I would believe that the supervisor would know to document incidents." -"Management is aware of the issues (incident reporting) now, since January 2022." -Did not report the allegation of abuse incidents dated 02/03/2022 for Client #3 or 02/24/2022 for	V 367		

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V 367	Continued From page 19 Client #2 to the LME within 72 hours of becoming aware of the incidents. Interview on 04/20/2022 with the Program Supervisor revealed: -"The person that it (incident) has been reported to is responsible for completing the IRIS report." -" ...I had no knowledge and was not trained right about the Incident Report IRIS process. I didn't know. I don't think it is a direct slack to Thompson (Licensee), I think it was who they had in the chair. [Residential Director] is laying out the groundwork and giving us basic training that we should have had previously." -"Within the last 2 months, she (Residential Director) has been training us." -Did not report the allegation of abuse incidents dated 02/03/2022 for Client #3 or 02/24/2022 for Client #2 to the LME within 72 hours of becoming aware of the incidents. Interview on 04/20/2022 with the Residential Director revealed: -"As soon as a child makes an allegation, the staff is put on administrative leave, compliance is notified, DSS (Department of Social Services) is notified, guardian contact and incident reporting is done." -Did not report the allegation of abuse incidents dated 02/03/2022 for Client #3 or 02/24/2022 for Client #2 to the LME within 72 hours of becoming aware of the incidents.	V 367		
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	V 512		

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V 512	Continued From page 20 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 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 11 Staff (#2 and #8) abused 1 of 3 Clients (#3). The findings are: Findings #1: Review on 03/21/2022 of Client #3's record revealed: -Admission date of 10/21/2021. -Diagnosed with Disruptive Mood Dysregulation Disorder, Unspecified Trauma and Stressor Related Disorder, Academic/Education Problems, and Attention Deficit Hyperactive Disorder (ADHD)- Combined type. -Comprehensive Clinical Assessment (CCA) dated 10/11/2021; History of verbal and physical	V 512	V 512 **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 quarterly which each quarter offering different times for all shifts to attend. 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 and 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 6/1/2022 By 7/1/2022 By 7/1/2022

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aggression towards other children, adults, law enforcement, and attention seeking behaviors such as intentionally urinating on himself, exhibiting immature behaviors, and excessive temper tantrums.
-Age 9.

Review on 03/23/2022 of Staff #2's record revealed:
-Hire date of 01/25/2021.
-Job title of Residential Care Specialist (RCS).
-Therapeutic Crisis Intervention (TCI) Training dated 05/20/2021.

Review on 03/21/2022-05/10/2022 of the facility's video surveillance for incident dated 01/29/2022 revealed:
Alphin Camera 2; 20 minutes of video footage from 12:55 pm - 01:15 pm.
-Staff #2 walked into recreational room where 2 clients were interacting in front of chalk board and Client #3 was standing in front of the bookcase. Client #3 selected a book, while Staff #2 stood, moved her hands and talked to Client #3. She pointed her finger and walked toward Client #3. Staff #2 grabbed 1 of 2 books out of his hands and put the book on the bookshelf.
-Staff #2 motioned for Client #3 to move. He began to walk, stopped as he entered the dining area started to walk and then ran around the table. Staff #2 pursued Client #3 as he ran around the table. Staff #2 and Client #3 faced each other at opposite sides of the table. Staff #2 pointed her finger at Client #3 and engaged in dialog. She pointed to the bookcase area and Client #3 began to walk to the bookcase. Staff #2 walked toward Client #3, still pointing her fingers, and stood face to face with Client #3 in front of the bookcase. Staff #2 grabbed Client #3 by his hands with both of her hands, swung him around,

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maneuvered behind him, picked him up, and carried him out of the recreational room.
-Client #3 kicked and grabbed onto the pillar in the center of the floor.
Alphin Camera 3, 20 minutes of video footage from 12:55 pm-01:15 pm.
-Staff #2 seated, watching tv, got up and walked to another area in the cottage. Staff #2 and Client #3 came into camera view at 12:58 pm. Staff #2 was carrying Client #3. He grabbed onto the pillar and Staff #2 pulled him off the pillar and took him to his room. Once in his room, Staff #2 closed Client #3's room door, stood in front of the door for approximately a minute and pulled a chair in front of the door. Client #3 opened the door, Staff #2 entered the room and began to remove items out of the room.
-A second staff (Staff #5) came in camera view at 1 pm. Staff #2 and #5 engaged in conversation. Staff #2 sat down and put her feet up on the doorframe. Client #3 attempted to come out of the room and she closed door again. Client #3 attempted to come out of the room again and Staff #2 entered room with the door closed for approximately 3 minutes.
-Staff #5 sat down and remained seated during the encounter between Staff #2 and Client #3.

Review on 03/22/2022, 03/23/2022 and 03/27/2022 of a document titled Investigation Report dated 02/02/2022 and completed by the Quality Improvement Specialist (QIS) revealed:
-" ...Date: 2/2/2022.
-RE: Allegation of Abuse.
-The Complaint/Allegations; Date: 01/31/2022.
-Incident (s): [Program Supervisor] notified PQI (Performance and Quality Improvement Department) on 2/1/22 via email of an allegation of abuse against staff member [Staff #2]. Supervisor reports that she was emailed Sunday

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V 512	Continued From page 23 evening (did not read until on duty Monday) regarding an unauthorized restraint and staff pinching the client. The email was forwarded from nursing after being reported by [Physician]. The email stated, "Hi I was rounding today by phone [unidentified person] and [Client #3] (A) made an allegation that a staff [Staff #2] pinched him and put him a restraint yesterday. I have not given a restrain order this weekend and wanted to pass this along for administration to check on it ... -Evidence/Documents Reviewed; ...Reviewed [Monitoring System] footage ... Shift Notes for 1/29/22 and 1/30/22, Incident Reports- No documentation of incident(s) on 1/29/22. -Conclusions: Based on interviews with staff and the consumer and camera review, it is determined that there is no evidence to validate the allegation of abuse. During the interview the client reported that he feels safe with staff but is sometimes placed on restrictions when he does not listen. Client additionally reported that he does not have any concerns and feels that staff treat him fairly. Staff reported that the client was not restrained over the weekend, and she has not participated in any intervention involving this consumer. QIS made efforts to speak to other staff present; however, she was unavailable at times contacted. QIS did receive a written statement from staff to which she reported not witnessing any behaviors and asserts that she has not observed any unprofessional behaviors from the staff alleged. -Date/Time the Investigation Was Completed: 02/03/2022." -Allegation not substantiated. Interview on 03/28/2022 with Client #2 revealed: -Never witnessed any of the other clients being mistreated.	V 512		

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Interview on 03/28/2022 with Client #3 revealed:
-Did not remember what happened.
-"I don't remember that day. I totally forgot what happened."

Interview on 03/25/2022 with the Facility's Physician revealed:
-Sent the email on 01/30/2022 on behalf of Client #3.
-"I did not say anything about abuse, a Complaint was made."
-"I would have to talk to them about the process. Sometimes I get notified that a child has been placed in a restraint if there is an emergency situation. Staff do try to call."

Interview on 04/21/2022 with Staff #2 revealed:
-"I spoke to someone about this week a few weeks ago. She came to the facility to talk to me. I did not place the child in a restraint. He was not placed in the restraint, he was jumping from bed to the shelf the shelf in his room and when I intervened he started screaming and antagonizing his peers (calling me a b***h and telling them to shut the f**k up). The other staff was seated in common area where she was able to see everything going on. I did not pinch him, he told me that another staff had pinched. He told me her name."

Interview on 04/21/2022 with Staff #5 revealed:
-"I honestly don't know what you are talking about. Oh, that (01/29/2022 incident) happened last year and I don't know what you are talking about."

Interview on 03/24/2022 with QIS revealed:
-Completed the Internal Investigation for the 01/29/2022 incident for Client #3.
-Unsubstantiated the allegation of abuse against

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V 512	Continued From page 25 Staff #2. -"I was not investigating for abuse. I was looking for the client being pinched. Other things were a concern, but my understanding was that I was investigating the client being pinched." -"She (Department of Social Services (DSS) Investigator) did not ask for it (video footage of 01/29/2022 incident)." Interview on 04/20/2022 with the Program Supervisor revealed: -"I was told about it (01/29/2022 incident). I read the email and reported it to [Residential Director], DSS, and PQI. I did not review camera footage, compliance does. I was not a part of the internal investigation process. Technically, I am not part of an investigation. If a client comes to me immediately, I will review footage, but technically do not do camera video reviews that's PQI. [Staff #2] is still a staff, but she has not been utilized. She can't be utilized until she do the TCI update. I did not review video footage for [Client #3]'s incident." Interview on 04/20/2022 with the Residential Director revealed: -"I can't speak to that (01/29/2022 incident details) and it is not anything that I would have put in place. It appears that there should have been sufficient evidence for more to be done with that employee (Staff #2). Our agency policy is that you do not go into a client's bedroom without another staff present and you definitely do not close the door. That is a problem within itself." Interview and observation on 03/24/2022 with the facility's TCI Instructor while reviewing video footage of the 01/29/2022 incident revealed: -"I am not sure why staff (Staff #2) went to get the	V 512		

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kid. He was not doing anything."
-"That was not any of the restraints we teach."
-"Staff should not be in a client's room with the door closed. When staff go in kids' rooms they should have another staff with them. You have a spotter if you have to go in a kid's room."
-"We shouldn't keep kids in their room against his will."
-"I used to be a supervisor and always talked to staff about monitoring, engaging, and not being in rooms with kids with the door shut."
-"I would say the physical contact was unnecessary. I did not see anything that would warrant what happened."
-"What happened in the video is not part of the TCI process or what we teach. I would say it was improper handling of the kid. Staff needs coaching. I don't know what to call that, but I don't think it is abuse."

Findings #2:

Review on 04/26/2022 of Staff #8's personnel record revealed:
-No date of hire provided.
-Job title of RCS.
-TCI Training dated 10/22/2021.

Review on 04/22/2022-05/10/2022 of the facility's video surveillance for incident dated 03/18/2022 revealed:
Alphin Camera 3; 4 minutes of video footage from 05:18 pm - 5:22 pm.
-Client #3 came into camera's view at 5:19 pm. Walked in living room area and walked out of view of camera. He ran into camera's view at 5:20 pm.
-2 Staff (#6 and #8) came into camera's view and Staff #8 began to go after Client #3, who was running around chairs in attempt to evade Staff

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V 512	Continued From page 27 #8. -Client #3 ran out of camera's view (went into another area of the cottage) and quickly re-emerged running. -Staff #6 was standing still in the living area and Staff #8 was still in pursuit of Client #3 as he continued to run around the cottage. Staff #8 extended her leg and made contact with Client #3 in attempt to trip him. Client #3 slightly stumbled but did not fall and continued to run. Another client began to chase Client #3 and grabbed and held him. Staff #8 approached and grabbed Client #3 and escorted him to his room and closed the door. Staff #6 placed chair in front of Client #3's door and stood holding the door closed for a few seconds. -Staff #8 walked out of view of the camera. Review on 03/29/2022 of a document titled Investigation Report dated 03/25/2022 and completed by the QIS revealed: -" ...Date: 03/25/2022. -RE: Allegation of Abuse. -The Complaint/Allegations; Date: 03/21/2022. -Incident (s): The [Client #3] met with his [therapist] on 3/21/22 and reported that a staff member [Staff #8] kicked him following a restraint on 3/18/2022. -Evidence/Documents Reviewed; Reviewed training transcript for [Staff #8], Review HR (Human Resource) documents for [Staff #8], View camera footage for 3/18 (server issues caused some buffering), Reviewed Shift Notes for 3/18/22. -Date/Time the Investigation Was Completed: 03/25/2022. -Conclusions: Based on interviews with staff, consumer, and review of the video there is evidence to show that staff member [Staff #8] placed her foot out appearing to kick or try to trip	V 512		

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the consumer. As a result of this review the allegation is validated. In speaking with the staff she conveys that she placed her foot out in an effort to prevent client from running."
-Allegation substantiated.

Interview on 03/28/2022 with Client #2 revealed:
-Never witnessed any of the other clients being mistreated.

Interview on 03/28/2022 with Client #3 revealed:
-"[Staff #8] kicked me."

Interview on 05/04/2022 with Staff #6 revealed:
-"The employee (Staff #8) was ignoring him (Client #3) and it frustrated him and it escalated him. She was arguing with the client and he said that she was going to get fired and she said she did not care. They were still arguing and he threw a toy at her and it pissed her off and she started to chase him around the cottage. She tried to kick him to trip him and she did make contact from what I saw. It should be on the cameras."

Attempted Interview on 05/04/2022 with Staff #8 was unsuccessful due to no response to phone call.

Interview on 05/04/2022 with Staff #9 revealed:
-"If you are talking about the kick thing. I did not see anything with my own two eyes."

Interview on 03/24/2022 with QIS revealed:
-"The Investigation (03/18/2022 incident) is still on going."
-Interviewed clients. [Client #2 refused to talk to her.
-Had not reviewed video footage.

Interview on 04/20/2022 with the Program

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V 512	Continued From page 29 Supervisor revealed: -"Yes, there was abuse with [Client #3]. They (Compliance Department) reviewed the camera footage and she (Staff #8) stuck out her foot to intentionally trip him and was terminated." Interview on 04/20/2022 with the Residential Director revealed: -"I am cleaning up a big mess, which I am sure you (Surveyor) can see. We are doing a complete overhaul. I (Residential Director) have been doing this for 15 years, but the system (processes) here has not caught up. I requested from my supervisor to downsize (close Alphin Cottage temporarily)." -"I report directly to Chief Program Officer." Review on 03/24/2022 of the POP dated and signed by the QIS on 03/24/2022 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? -Met w/ (with) all Program Supervisors to review documentation following incidents related to restraints and allegations (today @ 3:00 pm-4:30). -Send communications to all Alphin staff to provide information on client rights and least restrictive alternatives. -Retraining for all staff within 30 days for approved physical interventions and client rights training. Describe your plans to make sure the above happens. -Program director to ensure all staff are retrained on TCI Protocols. -Training and attendance will be documented those who fail to attend will be held accountable. -Camera review will be done to ensure safety (randomly) by program director and Quality Improvement Specialist."	V 512		

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V 512	Continued From page 30 Review on 03/25/2022 of the first POP Addendum dated and signed by the QIS on 03/25/2022 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? 1. The Psychiatric Residential Treatment Facilities (PRTF) Program Director met with all three program supervisors on Thursday 3/24/2022 to review the policy and procedures for documentation for incident reporting to include allegations of abuse and client behaviors or events that are not consistent with the routine operation and care of consumers in the PRTF. During the meeting the training coordinator reviewed TCI (therapeutic crisis intervention) and the expectations for restrictive interventions and use of de-escalation techniques that are complaint with the TCI training protocol. The quality improvement specialist reviewed the internal investigation process and the importance of supervisor follow-up with recommendations and areas of concern. 2. The PRTF Program Director emailed (3/24/2022) all current PRTF staff (Residential Care Specialist) working in Alphin Cottage the Residential Client Rights Manual to provide information on the expectations of behavior management to include approved behavior management techniques from least restrictive to most restrictive. Additionally, the program director highlighted the interventions that under no circumstance are permissible to use to manage client behaviors. 3. The Program Director, Training Coordinator, and Quality Improvement Specialist will provide retraining to Alphin staff (full time and PRN) within 30 days (Completed by 4/22/2022) for TCI and Client Rights with a specific focus on de-escalation and	V 512		

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V 512	Continued From page 31 approved physical interventions and behavior management techniques. Describe your plans to make sure the above happens. 1. The PRTF Program Director and PRTF program supervisors will ensure that all Alphin staff are signed up and retrained on TCI and client rights within the next 30 days. The PRTF Program Director will document the date of the training(s) and those in attendance. Any staff who fails to comply with or attend retraining will be held accountable with documented disciplinary action and will be removed from the schedule until training requirements are met. 2. Video observations will be conducted by the PRTF Program Director and Quality Improvement Specialist weekly to review Monitoring System footage to provide coaching and training to staff as needed." Review on 05/12/2022 of the second POP Addendum dated and signed by the Chief Performance and Quality Officer on 05/12/2022 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? 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 PQI (Performance and Quality Improvement Department) provided training to Residential Supervisors on Allegations of Abuse 3/25/2022 - Email from PRTF (Psychiatric	V 512		

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V 512	Continued From page 32 Residential Treatment Facilities) Director of Client Rights Manual and education of clients rights and prohibited behaviors sent to all residential staff. 3/30/2022 - Email to all residential staff from VP (Vice President) of Residential services regarding concerns of recent allegations of abuse 4/2/2022 - 4/14/2022 - Client Rights Manual acknowledgement sent out to all residential staff to sign and acknowledge via DocuSign 4/25/2022 - Residential Incident Reporting Operating Guidelines/protocols reviewed and updated by Residential Leadership. 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 [Sister Facility] 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. 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	V 512		

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progressive discipline policy will be utilized."

Client #3 was 9 years old and diagnosed with Disruptive Mood Dysregulation Disorder, Unspecified Trauma and Stressor Related Disorder, Academic/Education Problems, and ADHD. He had a history of verbal and physical aggression towards other children, adults, law enforcement and attention seeking behaviors such as intentionally urinating on himself, exhibiting immature behaviors, and excessive temper tantrums. Video footage within the facility, showed Staff #2 entered the area where Client #3 was standing, pointed her finger as she walked toward him and grabbed a book out of his hand. As Client #3 walked away, Staff #2 followed behind him and pursed him as he ran around the dining room table. Staff #2 grabbed Client #3 by his hands with both of her hands, swung him around, maneuvered behind him, picked him up, and carried him out of the recreational room against his will as evidenced by him kicking and grabbing onto the pillar in the center of the floor. Staff #2 pulled him off the pillar and took him to his room. Staff #2 placed a chair in front of Client #3's bedroom door, sat in the chair and restricted his ability to leave his bedroom freely. Staff #2 entered and remained in Client #3's bedroom alone with the door closed for roughly 3 minutes. Staff #2 did not report the 01/29/2022 incident. Client #3 reported the incident to the facility's doctor as an allegation of Staff #2 pinching and restraining him the day before. The Licensee did not substantiate the abuse allegation against Staff #2. In addition, the Licensee failed to put protective measures in place after the 01/29/2022 incident and Client #3 was abused by Staff #8 on 03/18/2022. Staff #8 chased Client #3 around the facility and when she could not catch him, she extended her leg and kicked him. Staff #8

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V 512	Continued From page 34 approached, grabbed, and escorted Client #3 to his room after he was caught by another client. Staff #8 closed Client #3's bedroom door and Staff #6 placed a chair in front of the door and held in closed. Again, Client #3's ability to exit his bedroom freely was restricted. 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		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of	V 537		

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V 537	Continued From page 35 training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain	V 537	V 537 **Correction:** 1. All RCS staff were 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. 2. All new RCS staff will be required to to attend TCI initial training during the New Employee Orientation period. **Prevention:** 1. Client Rights manual sign off for all RCS staff within 30 days of onboarding process. In addition to completion of the Client Rights training in Relias. 2. Video review of restrictive interventions to be conducted by Program Supervisors following intervention to ensure compliance with policies and procedures and TCI model. **Monitoring:** **1.** Program Supervisors will submit monthly update on RCS compliance standing with onboarding documentation. 2. Restrictive Intervention debriefing compliance will be reviewed at monthly leadership meeting by Program Director	Effective 6/1/2022 By 7/1/2022 By 7/1/2022

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documentation of initial and refresher training for at least three years.
(1) Documentation shall include:
(A) who participated in the training and the outcomes (pass/fail);
(B) when and where they attended; and
(C) instructor's name.
(2) The Division of MH/DD/SAS may review/request this documentation at any time.
(i) Instructor Qualification and Training Requirements:
(1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.
(2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out.
(3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.
(4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule.
(6) Acceptable instructor training programs shall include, but not be limited to, presentation of:
(A) understanding the adult learner;
(B) methods for teaching content of the course;
(C) evaluation of trainee performance; and

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V 537	Continued From page 37 (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers.	V 537		

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This Rule is not met as evidenced by:
Based on records review, interviews and observations, the facility failed to ensure staff demonstrated competency in restrictive interventions for 1 of 11 Staff (#2) and affecting 1 of 3 Clients (#2). The findings are:

Review on 03/21/2022 of Client #2's record revealed:
-Admission date of 8/9/2021.
-Diagnosed with Disruptive Mood Dysregulation Disorder, Reaction to Severe Stress, Unspecified and Attention Deficit Hyperactive Disorder (ADHD)- Combined type.
-Comprehensive Clinical Assessment (CCA) dated 08/03/2021; History of hospitalizations elopement behaviors, verbal and physical aggression, suicidal ideations, and homicidal threats.
-Age 9.

Review on 03/25/2022 of Staff #3's personnel record revealed:
-No date of hire.
-Job title of Residential Care Specialist (RCS).
-TCI Training dated 01/24/2022.

Review on 03/28/2022-05/10/2022 of the facility's video surveillance for incident dated 02/24/2022 revealed:
EAT Room Camera;
-Client #2 seated against the wall between Staff #3 and #4.
-Staff #3 stood up, Client #2 and Staff #4 still seated.
-Client #2 looked around and moments later, got up and started to run.

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V 537	Continued From page 39 -Staff #3 ran after him and reached to grab him. Client #2 fell on stage and Staff #3 fell on top of him. Review between 03/21/2022-03/23/2022 of a document titled Investigation Report dated 02/24/2022 and completed by the QIS revealed: -"Date: 02/25/2022. -RE: Complaint of Improper/Undocumented Restraint using excessive force. -The Complaint/Allegations; Date: 02/25/2022. -Incident (s): [Program Supervisor], was made aware that [Client #2] communicated that he had been restrained multiple times during first shift on 02/24/2022. Supervisor reviewed documentation and noted that client had only one documented restraint during the shirt, prompting her to conduct video observations. Upon review of the video staff were observed in the EAT room with the client where one staff was observed falling on the client and then holding him appearing to attempt a restraint. Due to the nature of observation Supervisor requested PQI (Performance Quality Improvement) review the footage and speak with the consumer. -Pre-Investigation Actions: Supervisor reviewed footage and requested assistance from PQI on 2/25/2022, QIS viewed footage and advised supervisor to contact [Residential Director] to make her aware of the concerns and allow her to view footage on [Monitoring System], [Residential Director] reviewed footage and notified QIS that staff member (Staff #3) would be removed from the schedule pending further review to determine nature of events, QIS obtained contact information for all staff present during incident on 2/24/22, [Residential Director] requested full internal investigation on 3/2/2022. -Evidence/Documents Reviewed: Reviewed [Monitoring System] footage for EAT Room	V 537		

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V 537	Continued From page 40 2/24/2022 11:00a-11:10a, [Client #2] EHR in [Data base] Incident/RI reports week of 2/21/2022-2/25/2022, Shift note for 2/24/2022 1st shift ... -Conclusions: Based on interviews with staff, the consumer, and review of the camera footage it was confirmed that an improper restraint took place in the EAT Room on 2/24/2022 and it was not documented in [Data Base] or IRIS system. The staff interviewed confirmed that there was physical contact with the client after he attempted to elope; however, staff reported that a restrictive intervention was not attempted, and that staff tripped falling on the client while attempting to prevent client from going AWOL. Based on the interview with the client he reported that he was restrained by staff but did not recall what happened, but otherwise he feels safe, and that staff are generally nice to him. Based on review of the camera footage the concern that staff performed a restrictive intervention and failed to complete documentation is validated. Additionally, the concern that staff used excessive force is also validated as a result of staff holding the client and restricting movement using unapproved techniques and failing to use less restrictive interventions to de-escalate the client. -Date/Time the Investigation Was Completed: 03/03/2022." -Allegation substantiated. Review between 03/28/2022-05/10/2022 of a document titled Investigation Report Addendum not dated and completed by the QIS revealed: -"Concerns: Camera review shows that staff isolated client from the group and at one point stood over him which could be interpreted as intimidation. Staff did not use approved TCI interventions when attempting to restrain the consumer."	V 537		

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V 537	Continued From page 41 -"Staff does not acknowledge that a restrictive intervention occurred although the client was held and prevented from moving freely." -"During interviews and communication with supervisors it is reported that [Staff #3] is generally a good employee; however, she is viewed as non-therapeutic and "more authoritarian than other staff ..." Review between 03/28/2022-05/10/2022 of a document titled Personnel Action Form (PAF) with effective date 03/14/2022 and signed by the Vice President of Operations revealed: -"Action: Transfer. -Employee Name: [Staff #3] ... -Project Code: 845- PRTF School. -Job Title: Teacher Assistant ... -Required: Notes: [Staff #3] has expressed interest in joining the PRTF school team. She has displayed abilities to maintain and support academic enrichment, specifically during challenging items in the school environment ... -Approvals: Education Supervisor signed and dated 03/11/2022 and Vice President of Operations signed and dated 03/11/2022." Interview on 03/28/2022 with Client #2 revealed: -"She (Staff #3) did restrain me multiple times in one day. She stopped working with me like a month ago. I lied on her to say she hit me when she didn't to get rid of her. She is the one that always yell. She is one of the dumpiest and meanest staff that work here." Attempted Interview on 03/28/2022 with Client #3 was unsuccessful due to refusal to answer any questions about the incident. Interview on 05/05/2022 with Staff #3 revealed: -"[Client #2] was exhibiting impulsive behaviors,	V 537		

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being disrespectful, antagonizing peers. Once we got ready to leave school and transition to the EAT room. He was restrained. There was only 1 documented restraint that happened outside and beside the van."
-"I did restrain him outside, we called the therapist, therapist called the nurse and the nurse approved the restraint. After the restraint we redirected him and told him he was going to sit between me and my staff. He did. He has a history of elopement. He started taking off his shoes and became agitated and told staff he was getting ready to run. He got up and ran and I was already standing and began to chase him. He jumped up on the stage and I tripped over the stage trying to jump on it and fell on the back of his leg and got up. I grabbed him by his wrist and he picked up clay and threw it at my face. He got calm."
-"[Program Supervisor] called and said I was clear to come back to work. They (Licensee) said I could come back and it (the investigation) was done."

Interview on 05/05/2022 with Staff #4 revealed:
-"I can't really remember what he was doing. He had to be put in a restraint right then. [Client #2] is a runner and that is his time. I can't tell exactly what happened. I think he tried to run off the van and that's why [Staff #3] did the restraint. His behaviors were off that morning, we were on the van, he got aggressive, tried to fight [Staff #3], he tried to kick the windows in the van. [Staff #3] restrained him then. Once she let him out the restraint we took him to the game room. He was saying he wanted to run and we kept him close. We transported him to the EAT and sat him between us (Staff #3 and #4). I knew he was going to run and he displayed signs; looking for the exit and to see where staff is. Me and [Staff

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V 537	Continued From page 43 #3] already knew that so, we positioned him between us. He started running and he jumped on stage. Him and [Staff #3] fell and tripped on the stage. I started to tip but I caught myself but they fell. He got up and I don't remember anything being wrong with him. They never cleared the stage. If the stage would not have been there, they would have never fell." -"No nothing happened that was out of the norm. When he is about to run, he does not see the danger in things. For him to run like that and him to fall is not out of the ordinary. When he is in that mode it is unsafe for him to be in open environment. Thompson is not secure enough for him. I have watched him jump in front of cars on and off campus. He needs to be in a place that is not opened. Opened platform he will plot to run." Interview on 03/24/2022 with the QIS revealed: -Program Supervisor requested PQI investigate the 02/24/2022 incident. -There was documentation of only 1 approved restraint for Client #2 on 02/24/2022. -Staff #3 remain employed on an as needed basis (PRN). Interview on 04/20/2022 with the Program Supervisor revealed: -"The EAT room footage was a little questionable. I called compliance and [Program Director] told them to look at footage. Staff was put on leave and she kept calling me and I told her that compliance is investigating and I will reach out to her and tell her the results. I got a call a few days later from [Program Director] saying that I can utilize her on my schedule. After that, she was moved to the school to work. She said she could not work a 12 hour shift and she was one of the staff that was moved to the school. She was paid money for the days she missed work."	V 537		

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V 537	Continued From page 44 Interview on 04/20/2022 with the Residential Director revealed: -"Per my leadership, staff are now terminated. She should have been terminated. I recommended for her not to transition to the school. My supervisor made the recommendation for the transition. When I see excessive force, it is automatic termination. Since that allegations, I think there has been five more (abuse incidents) and five staff have been terminated."	V 537		
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 observations and interviews, the facility failed to maintain water temperatures between 100-116 degrees Fahrenheit (°F). The findings are: Observation of the facility on 03/30/2022 between 10:16 am - 11: 00 am revealed: -Bathroom #1 hot water temperature in sink 70°F and shower 60°F. -Bathroom #2 hot water temperature in sink 70°F and shower 75°F. -Bathroom #6 hot water temperature in sink 79°F	V 752	V 752 **Correction:** 1. Chief Facilities Officer verified water temperature following survey and found temperature to be in compliance with DHSR regulation. **Prevention:** 1. Program Supervisor and or Program Director will conduct weekly cottage walk through's to observe an note deficiencies and make necessary corrections. **Monitoring:** 1. Chief Facilities Officer will continue to monitor and check temperature monthly to ensure temperatures are maintained in the appropriate range.	

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V 752	Continued From page 45 and shower 78°F. -Kitchen hot water temperature in sink 60°F. Interview on 03/30/2022 with Client #1 revealed: -"It's (water) cold." -"Nobody, because they (staff) just gonna say get in and get out." Interview on 03/30/2022 with Client #2 revealed: -"It (water) is good." -"No. It's always good." -Water is too cold sometimes. -Did not report cold water to staff. -"I pretend I take a shower when it's too cold and only take a shower when it's hot." Interview on 03/30/2022 with Staff #1 revealed: -"I know that the hot water will run out when the cottage is full of kids." -"They (clients) will complain about the shower (water) being cold." -"It has been going on since I got here which is 10/05/2020." Interview on 03/30/2022 with Quality Improvement Specialist (QIS) revealed: -"Yes, I will call maintenance to make sure." -"What should the temperature be?" Interview and observation on 03/30/2022 between approximately 10:35 am-11:05 am with the facility's Maintenance Worker revealed: -"We use digital temperature gages. Is it okay, if I go get it?" -Checked water temperature in kitchen; 88 °F read. -"You (Surveyor) ran the hot water out." -"I am sorry for accusing you of running the hot water out, you actually didn't let it run long enough. You can go back to re-check it. I just got	V 752		

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V 752	Continued From page 46 a reading of 117 at [other facility]." Interview on 03/30/2022 with the facility's Chief Facilities Officer revealed: -"I am not sure what you (Surveyor) and [Maintenance Worker] did, but I checked the temperature and its normal. We just passed our annual inspection. I use a digital thermometer that I paid $400 for and it gives much more accurate reads than the glass thermometer you use. I have been doing this for 30 years and everyone knows to do a check from one water source." Interview on 04/20/2022 with the Program Supervisor revealed: -"I have not noticed the water being too cold or too hot. That has not been a concern."	V 752		