STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL047-131	A. BUILDING: _____ B. WING _____	C 09/26/2022

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HOPE GARDENS TREATMENT CENTER	1958 TURNPIKE ROAD RAEFORD, NC 28376

(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 A complaint and follow up survey was completed on September 26, 2022. The complaint was substantiated (intake #NC00192601). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents. This facility is licensed for 12 and currently has a census of 11. The survey sample consisted of audits of 5 current clients.	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills;	V 110		

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V 110	Continued From page 1 (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record review and interviews one of four staff (the Vice President of Operations) failed to demonstrate the knowledge, skills and abilities required for the population served. The findings are: Cross Reference: 131E-256 Health Care Personnel Registry (V132). Based on record review and interview, the facility failed to ensure an allegation of abuse was reported to Health Care Personnel Registry (HCPR) within five working days. Cross Reference: 10A NCAC 27G .0603 Incident Response Requirements for Category A and B Providers (V366). Based on record review and interviews, the facility failed to implement a policy governing their response to Level III incidents as required. Cross Reference: 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers (V367). Based on record review and interviews, the facility failed to ensure incidents were reported to the Local Management Entity/Managed Care Organization (LME/MCO)	V 110		

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V 110	Continued From page 2 for the catchment area where services are provided within 72 hours of becoming aware of the incident.	V 110		
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 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		

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V 132	Continued From page 3	V 132		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure an allegation of abuse was reported to Health Care Personnel Registry (HCPR) within five working days. The findings are:

Review on 9/14/22 of client #1's record revealed:
-Admission date of 3/9/22.
-Diagnoses of Post Traumatic Stress Disorder, Intermittent Explosive Disorder, Attention Deficit Hyperactivity Disorder and Disruptive Mood Dysregulation Disorder.
-He was 12 years old.
-Assessment dated 3/9/22 had the following-He had a history of anger outbursts, erratic mood swings, homicidal threats, instigating fights and causing harm to others.

Review on 9/14/22 of a In-house incident report dated 8/28/22 revealed:
-"Several clients reported to multiple staff members today that a staff member, [Former Staff #4] assaulted [client #1] in the evening of 8/27/22. The clients that were willing to talk about the incident all agreed that [client #1] provoked

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V 132	Continued From page 4 [FS #4] repeatedly...[FS #4] reportedly came to work in a bad mood and had warned the clients not to provoke him on this particular day...[FS #4] used profanity and threatened the client with physical consequence. According to witnesses, [FS #4] stated that it was [client #1's] last warning and [client #1] ran out of his room again and then they only saw [FS #4] enter [client #1's] room and heard loud banging noises. They heard [client #1] screaming in pain. They heard [client #1] yelling and swearing and heard [FS #4] use profanity and threats back to [client #1]. They heard [client #1] say he was going to bite [FS #4] and then heard [FS #4] say he dared [client #1] to. Next, they heard [FS #4] scream and then some of the clients saw [client #1] on the floor of his room and saw [FS #4] standing over [client #1] with his arms moving. The clients all stated that [staff #1] and [staff #2] both ran to the incident and were trying to verbally and physically remove [FS #4] from [client #1] by physically pulling on [FS #4] and saying something like C' mon (come on) [client #1] only a little kid...[Client #1] has a fresh scratch on his right collar bone about an inch long." Review of the Incident Response Improvement System (IRIS) on 9/14/22 revealed: -There were no level III incident reports submitted by the facility for the above incident. Interview on 9/14/22 with the Vice President of Operations revealed: -She was aware of the incident with client #1 and FS #4. -She would normally report an allegation of abuse to HCPR through IRIS. -The Director of Operations and other management staff did the investigation and she was supposed to put the results into IRIS.	V 132		

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V 132	Continued From page 5 -She thought she pressed save and forgot to press submit and therefore that incident was not reported to HCPR through IRIS. -She confirmed the agency failed to report the allegation of abuse to HCPR within five working days. This deficiency is cross referenced into 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS(V110) for a standard level deficiency and must be corrected within 60 days.	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 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	V 366		

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V 366	Continued From page 6 (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; (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	V 366		

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V 366	Continued From page 7 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 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 review and interviews, the	V 366		

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V 366	Continued From page 8 facility failed to implement a policy governing their response to Level III incidents as required. The findings are: Review on 9/14/22 of client #1's record revealed: -Admission date of 3/9/22. -Diagnoses of Post Traumatic Stress Disorder, Intermittent Explosive Disorder, Attention Deficit Hyperactivity Disorder and Disruptive Mood Dysregulation Disorder. -He was 12 years old. -Assessment dated 3/9/22 had the following-He had a history of anger outbursts, erratic mood swings, homicidal threats, instigating fights and causing harm to others. Review on 9/14/22 of a In-house incident report dated 8/28/22 revealed: -"Several clients reported to multiple staff members today that a staff member, [Former Staff #4] assaulted [client #1] in the evening of 8/27/22. The clients that were willing to talk about the incident all agreed that [client #1] provoked [FS #4] repeatedly...[FS #4] reportedly came to work in a bad mood and had warned the clients not to provoke him on this particular day...[FS #4] used profanity and threatened the client with physical consequence. According to witnesses, [FS #4] stated that it was [client #1's] last warning and [client #1] ran out of his room again and then they only saw [FS #4] enter [client #1's] room and heard loud banging noises. They heard [client #1] screaming in pain. They heard [client #1] yelling and swearing and heard [FS #4] use profanity and threats back to [client #1]. They heard [client #1] say he was going to bite [FS #4] and then heard [FS #4] say he dared [client #1] to. Next, they heard [FS #4] scream and then some of the clients saw [client #1] on the floor of his room and saw [FS #4] standing over [client #1] with his	V 366		

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V 366	Continued From page 9 arms moving. The clients all stated that [staff #1] and [staff #2] both ran to the incident and were trying to verbally and physically remove [FS #4] from [client #1] by physically pulling on [FS #4] and saying something like C' mon (come on) [client #1] only a little kid....[Client #1] has a fresh scratch on his right collar bone about an inch long." Review of the Incident Response Improvement System (IRIS) on 9/14/22 revealed: -There was no documentation of an incident report completed by the Vice President of Operations or other management staff for the above issue. -There was no documentation to determine: The cause of the incident; no corrective measures according to the provider specified timeframes not to exceed 45 days; no measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days and assigning person(s) to be responsible for implementation of the corrections and preventive measures. Interview on 9/15/22 with the Executive Director revealed: -The Vice President of Operations was responsible for ensuring the above incident was put into IRIS. -The Nurse or First Responder during that shift would normally do the In-house incident report. -The Vice President of Operations would put the information from that In-house incident report into IRIS. -He confirmed the facility failed to implement a policy governing their response to Level III incidents as required. Interview on 9/14/22 with the Vice President of Operations revealed:	V 366		

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V 366	Continued From page 10 -She was aware of the incident with client #1 and FS #4. -She was responsible for putting that incident into IRIS. She didn't put incidents into IRIS as often anymore. -She thought she pressed save and forgot to press submit and therefore that incident was not reported to IRIS. -She confirmed the facility failed to implement a policy governing their response to Level III incidents as required. This deficiency is cross referenced into 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS(V110) for a standard level deficiency and must be corrected within 60 days.	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 information:	V 367		

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V 367	Continued From page 11 (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 immediately, as required by 10A NCAC 26C	V 367		

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V 367	Continued From page 12 .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 review and interviews, the facility failed to ensure incidents were reported to the Local Management Entity/Managed Care Organization (LME/MCO) for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are: Refer to V-366 regarding implementing a policy governing their response to Level III incidents.	V 367		

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V 367	Continued From page 13 -There was an allegation of abuse involving FS #4 and client #1. -Review of the Incident Reporting Improvement System (IRIS) revealed the Vice President of Operations failed to report to the incident to the LME/MCO within 72 hours. This deficiency is cross referenced into 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS(V110) for a standard level deficiency and must be corrected within 60 days.	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 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	V 512		

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V 512	Continued From page 14 dismissal of the employee. This Rule is not met as evidenced by: Based on record reviews and interviews, one of one former staff (FS #4) abused one of five current audited clients (#1) and two of three current audited staff (#1 and #2) neglected one of five current audited clients (#1). The findings are: Review on 9/14/22 of the facility's personnel records revealed: FS #4: -Date of hire was 6/28/20. -He was hired as a Residential Mentor. -He was terminated on 8/28/22. Staff #1: -Date of hire was 5/8/22. -He was hired as a Residential Mentor. Staff #2: -Date of hire was 9/25/20. -She was hired as a Residential Mentor. Review on 9/14/22 of client #1's record revealed: -Admission date of 3/9/22. -Diagnoses of Posttraumatic Stress Disorder, Intermittent Explosive Disorder, Attention Deficit Hyperactivity Disorder and Disruptive Mood Dysregulation Disorder. -He was 12 years old. -Assessment dated 3/9/22 had the following-He had a history of anger outbursts, erratic mood swings, homicidal threats, instigating fights and causing harm to others. Review on 9/14/22 of a In-house incident report	V 512		

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V 512	Continued From page 15 dated 8/28/22 revealed: -"Several clients reported to multiple staff members today that a staff member, [FS #4] assaulted [client #1] in the evening of 8/27/22. The clients that were willing to talk about the incident all agreed that [client #1] provoked [FS #4] repeatedly...[FS #4] reportedly came to work in a bad mood and had warned the clients not to provoke him on this particular day...[FS #4] used profanity and threatened the client with physical consequence. According to witnesses, [FS #4] stated that it was [client #1's] last warning and [client #1] ran out of his room again and then they only saw [FS #4] enter [client #1's] room and heard loud banging noises. They heard [client #1] screaming in pain. They heard [client #1] yelling and swearing and heard [FS #4] use profanity and threats back to [client #1]. They heard [client #1] say he was going to bite [FS #4] and then heard [FS #4] say he dared [client #1] to. Next, they heard [FS #4] scream and then some of the clients saw [client #1] on the floor of his room and saw [FS #4] standing over [client #1] with his arms moving. The clients all stated that [staff #1] and [staff #2] both ran to the incident and were trying to verbally and physically remove [FS #4] from [client #1] by physically pulling on [FS #4] and saying something like C' mon (come on) [client #1] only a little kid...[Client #1] has a fresh scratch on his right collar bone about an inch long." Interview on 9/14/22 with client #1 revealed: -There was an incident with FS #4 just recently. -He could not remember the exact date, it was a few weeks ago. The incident occurred during 2nd shift and he thought most of the clients were in their bedroom possibly sleeping. -FS #4 seemed to be in a bad mood at the beginning of his shift. He was in his bedroom and	V 512		

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heard FS #4 say "don't f*****g mess with me because I'm not in the mood today."
-He told FS #4 "you don't have to talk to us like that."
-FS #4 said "do something about it you p***y."
-He then went to get water and FS #4 said why are you out of your room, why are you messing with me.
-He told FS #4 "you not going keep talking to me like that." He told FS #4 "if you try to hurt me, I will bite you."
-FS #4 was standing close to him and he thought FS #4 was going to hurt him.
-He was standing in the doorway of his bedroom arguing with FS #4.
-FS #4 then pushed him in his chest. He fell onto the floor in his bedroom and hit his head on the wall.
-He was laying on the floor in the corner of bedroom and FS #4 picked him up by his shirt with one hand. FS #4 had him by neck with the other hand. FS #4 choked his neck.
-A few seconds later staff #1 grabbed FS #4 and pushed him against the wall.
-When staff #1 pushed FS #4 against the wall he started biting FS #4 on his leg.
-He saw staff #2 during that incident, however he thought she was just watching.
-He did not recall staff #2 intervening during that incident.
-FS #4 scratched his neck during that altercation. He thought his neck was also bleeding.

Interview on 9/14/22 with client #3 revealed:
-He witnessed the recent incident with client #1 and FS #4.
-FS #4 told them earlier, "I 'm not in a good mood, so don't mess with me."
-Client #1 was running around the common area of the facility. Client #1 kept saying he was

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V 512	Continued From page 17 hungry. -FS #4 and staff #1 kept telling client #1 to go back to his bedroom. -He then saw FS #4 push client #1 into his bedroom and he fell onto the floor. FS #4 shoved client #1 hard when he pushed him. -He could hear them calling each other a "b***h." -Client #1 told FS #4 he would bite him. FS #4 said "I'm going to f**k you up." -Then he saw FS #4 standing over client #1 while he was on the floor. FS #4 was choking client #1's neck. -Client #1 then grabbed FS #4's leg and started biting him on his leg. -Staff #1 was trying to separate client #1 and FS #4, however he was having a hard time. -He saw staff #2 go into the bedroom and help separate client #1 and FS #4. Interview on 9/14/22 with client #4 revealed: -He was aware of the incident with client #1 and FS #4. -When FS #4 arrived on the unit for his shift he said "I had a bad day and don't bother me." -He did not see the incident, however he heard a loud "thud" in client #1's bedroom. -He could hear client #1 and FS #4 talking, however he couldn't understand what they were saying. Interview on 9/14/22 with client #5 revealed: -He never saw anything during that incident with client #1 and FS #4. -He was in his bedroom and trying to fall asleep. He heard some of the incident. -He heard client #1 yelling at FS #4. He heard FS #4 telling client #1 to shut up. Interview on 9/14/22 with staff #1 revealed: -He witnessed the incident with client #1 and FS	V 512		

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V 512	Continued From page 18 #4 in August 2022. -Most of the clients were in their bedrooms during that incident. -During that incident client #1 was running in and out of his bedroom. -He and FS #4 told client #1 to stop running in and out of his bedroom. -He then heard client #1 and FS #4 exchanging words. They were "cussing" at each other and he could not remember the specific words they were saying to each other. -Client #1 was standing in the doorway of his bedroom when he was arguing with FS #4. -He saw FS #4 push client #1 in his back into his bedroom. -FS #4 pushed client #1 with force because client #1 fell onto the floor in his bedroom. -FS #4 then went into client #1's bedroom and was still "cussing" and "fussing" at him. -Client #1 was still laying on the floor, he was laying in the corner of the bedroom. -FS #4 kept saying to client #1 "I dare you to bite me, I dare you to bite me." -Client #1 was still on the floor and somehow bit FS #4's arm. -He was standing in between FS #4 and client #1. He was trying to separate them. -Client #1 then got around his leg and was trying to bite him. -Client #1 stopped and started biting FS #4's leg instead. -He saw FS #4 pulling client #1 around the collar of his shirt when he was biting his leg. -He didn't know if FS #4 was choking client #1's neck. -He called for staff #2 and she helped him separate client #1 and FS #4. -FS #4 did leave the unit for about 15 minutes, however he returned and completed his shift. -He didn't report that incident to management	V 512		

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when it happened.
-He was a newer staff and wasn't sure how he should have handled that incident.

Interviews on 9/14/22 and 9/15/22 with staff #2 revealed:
-She did recall the incident with FS #4 and client #1 in August 2022.
-She didn't witness most of that incident. She was on the other hallway with a client who was having a crisis.
-During that incident staff #1 called for her and when she went into the bedroom she saw client #1 biting FS #4's leg.
-She intervened by moving client #1 away from FS #4.
-She left client #1's bedroom after that because she had to go back to be with the other client.
-She couldn't remember if FS #4 completed his shift after that incident.
-She didn't report the incident to management.
-She thought staff #1 was responsible for reporting that incident to management.
-She couldn't remember if FS #4 completed his shift after that incident.

Attempts on 9/14/22 and 9/15/22 to interview FS #4 were unsuccessful because he failed to return the phone calls.

Interviews on 9/14/22 and 9/15/22 with the Executive Director revealed:
-He was aware of the incident with client #1 and FS #4 on 8/27/22.
-It was alleged that FS #4 got into a physical altercation with client #1.
-Client #1 alleged FS #4 choked his neck.
-When he came to the facility on 8/28/22 some of the clients told him there was an incident. The clients said the incident occurred the previous

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night and it involved FS #4 and client #1.
-"According to some of the clients [FS #4] came in with a bad attitude."
-The clients said client #1 started calling FS #4 names and it "escalated" from there.
-"Some of the clients said they heard a lot of bumping against the wall", however they did not witness the incident.
-He contacted staff #1 on 8/28/22 because he witnessed most of that incident with client #1 and FS #4.
-Staff #2 was also involved in the incident, however it was his understanding she intervened towards the end of the incident.
-Staff #1 and staff #2 never reported the incident with client #1 and FS #4 to him or other management staff.
-Staff are supposed to report incidents to management immediately.
-Staff #1 was a newer staff and possibly didn't know what to do during that incident.
-He wasn't sure why staff #2 failed to report the incident to management.

Interviews on 9/14/22 and 9/15/22 with the Director of Operations revealed:
-He was aware of the incident with FS #4 and client #1 on 8/27/22.
-He was responsible for completing the investigation involving FS #4 and client #1.
-Staff #1 witnessed the incident with FS #4 and client #1.
-Staff #1 "corroborated" the details client #1 told about the incident with FS #4.
-FS #4 was terminated as a result of the incident on 8/28/22.

Review on 9/15/22 of a Plan of Protection written by the Executive Director dated 9/15/22 revealed: "What immediate action will the facility take to

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ensure the safety of the consumers in your care? Staff will be monitored more thoroughly by immediate supervisor on what their job duties Intel. Immediate Supervisor will monitor staff tone-volume-cadence towards alls consumers. Staff would receive additional training on Rational Detachment immediately. [FS #4] was relieved from his duties as Residential Mentor. Describe your plans to make sure the above happens. During biweekly supervision these matters will be addressed where staff receive ongoing training. Staff also would under go CPI (Crisis Prevention Institute) Training on when it's feasible to do restrictive intervention."

Client #1's diagnoses included: Posttraumatic Stress Disorder, Intermittent Explosive Disorder, Attention Deficit Hyperactivity Disorder and Disruptive Mood Dysregulation Disorder. Client #1 was 12 years old. There was an incident on 8/27/22 with client #1 and FS #4. FS #4 and client #1 were arguing back and forth with each other. The incident started as a verbal altercation and escalated into a physical altercation with FS #4 pushing client #1 down and choking him. Client #1 bit FS #4's arm and leg during the altercation. Staff #1 and staff #2 intervened and separated client #1 and FS #4. Client #1 had a scratch on his right collar bone after the incident. FS #4 completed his shift after the incident with client #1. Staff #1 and staff #2 never reported that incident to any management staff. FS #4 was terminated on 8/28/22 as a result of the incident.

This deficiency constitutes a Type A1 rule violation for serious abuse and serious neglect must be corrected within 23 days. An administrative penalty of $1500.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per

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V 512	Continued From page 22 day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 512		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure facility grounds were maintained in a safe, clean, attractive, orderly manner and kept free from offensive odor. The findings are: Observation on 9/14/22 at approximately 1:45 pm revealed: -Common area of facility-Walls had peeling paint. -Client #1's bedroom-Doorframe had peeling paint. -Client #2's bedroom-Doorframe had peeling paint. Door was dented. Paint on walls was faded. -Client #5's bedroom-Knob to door was missing. Blinds were broken. Paint on walls was faded. -Client #7's bedroom-Doorframe had peeling paint. Door had writing on it. Walls had peeling paint. Ceiling had black markings. -Bathroom #1-Paint peeling and faded on walls. Door was rusted. -Bathroom #2-Crack in wall of shower. Ceiling had dirt like stains on it. Door and frame of door was rusted.	V 736		

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V 736	Continued From page 23 -Client #4's bedroom-Writing on the door. Doorframe was rusted. Ceiling vent cover was missing. Paint on walls was faded. -Client #6's bedroom-Paint on walls was faded. Blinds were broken. -Client #8's bedroom-Paint on walls was faded. Plexiglass window had a plum sized hole. Ceiling vent cover was missing. -Client #9's bedroom-Paint on walls was faded. Blinds were broken. -Bathroom #3-Strong urine smell. Grayish markings on the ceiling. Paint on walls was faded -Empty bedroom-Ceiling vent cover was missing. Doorframe was rusted. Walls were stained. -Client #10's bedroom-Doorframe was rusted. Walls had peeling paint. -Client #11's bedroom-Knob to door was missing. Doorframe was rusted. Writing on the door. Ceiling vent cover was missing. Blinds were broken. Interview on 9/14/22 with the Executive Director revealed: -He were aware of the maintenance issues with the facility. -He put in work orders for some of those maintenance issues. They were still waiting to have the repairs completed for the facility. -He confirmed the facility failed to ensure facility grounds were maintained in a safe, clean, attractive, orderly manner and kept free offensive odor. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		