STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(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 October 6, 2022. The complaints were substantiated (intake #NC00192924, #NC00193054 and #NC00193750). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1800 Intensive Residential Treatment for Children and Adolescents. This facility is licensed for 12 and currently has a census of 7. The survey sample consisted of audits of 7 current clients and 2 former clients. This survey originally closed on 09/27/22 and was reopened on 10/6/22 due to an additional complaint.	V 000		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making;	V 109		

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V 109	Continued From page 1 (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record reviews and interviews, one of two former Qualified Professionals (FQP #1) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are: Cross Reference: G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (Tag V132). Based on record reviews and interviews, the facility failed to ensure that the Health Care Personnel Registry (HCPR) is notified of an allegation of abuse against health care personnel and failed to investigate allegations of abuse. Cross Reference: 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR	V 109		

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V 109	Continued From page 2 CATEGORY A AND B PROVIDERS (Tag V367). Based on record reviews and interviews, the facility failed to ensure critical incident reports were submitted to the Local Management Entity (LME)/Managed Care Organization (MCO) within 72 hours as required. Cross Reference: 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (Tag V500). Based on record review and interviews, the governing body failed to report an allegation of abuse to the Department of Social Services (DSS) affecting one of six audited current clients (#2). Review on 09/22/22 of FQP #1's record revealed date of hire 06/02/22. Review on 09/22/22 of the staff list completed by current QP revealed: - FQP #1's date of separation was 09/19/22. Attempts to contact the FQP #1 on 09/20/22 were unsuccessful and no ability to leave a message. Interview on 09/22/22 the Program Manager stated: - The FQP #1 had recently resigned from the facility. - The FQP #1 was responsible for completing investigations and reports. - She had been on leave for several weeks in August 2022. - She understood the FQP #1 had failed to complete documents, investigations and submit required reports.	V 109		

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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; (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 reviews and interviews one of	V 110		

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V 110	Continued From page 4 three former staff (FS #7) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are: Review on 09/22/22 of FS #7's record revealed: -Hire date of 06/16/22. -Separation date: 09/14/22. -Direct Care Staff. Review on 09/20/22 of the facility surveillance footage (no date or time) revealed: -FS #7 laying on his back on the dining room table asleep holding a coke bottle in his right hand. During interview on 09/22/22 staff #2 revealed: -She had worked at the facility for 3 or 4 months and resigned effective 09/21/22. -She had worked on 3rd shift (12 midnight to 8am). -FS #7 had worked on her shift previously and acted like "he was high off something." -FS #7 had his shirt off and was walking up and down the hallway. -All the clients were asleep in their rooms. -The facility was very quiet and FS #7 was saying "shut the f**k up" to himself. -FS #7 fell asleep on the table. -She told the former Qualified Professional (FQP) #2 about FS #7's behavior. -There were 4 staff that worked that night. During interview on 09/22/22 staff #5 revealed: -He worked with FS #7 on 3rd shift. -He kept telling FS #7 to wake up. -FS #7 was laying on the table asleep and he spilled his drink on his shirt. -FS #7 took his shirt off. -FS #7 was very "tired and a mess." During interview on 09/21/22 FS #7 revealed:	V 110		

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V 110	Continued From page 5 -He worked the 3rd shift from 12am-8am. -Staff on 3rd shift are not allowed to sleep. -It was 3rd shift, and it was "natural" to fall asleep. -When he did fall asleep it would only be for 10 to 15 minutes. -He did not "trust the kids to stay asleep longer than that." -The night he had his shirt off and fell asleep was because he had a 10-month-old son. -He had not had any sleep and when he went into work he was "tired and delirious." -He fell asleep on the table. -He had a coke in his hand and spilled the coke which was why he took his shirt off. -He was accused of being on drugs and told administration he would take a drug test and he never heard anything else from them. Interview on 09/20/22 and 09/21/22 the FQP #2 stated: -FS #7 was not supposed to be working on 3rd shift due to supervision issues in the past. -Staff #2 took a picture of FS #7. -FS #7 appeared to be "under the influence." Interview on 09/22/22 the Program Director stated she understood the concerns identified with FS #7's behaviors.	V 110		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to	V 112		

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V 112	Continued From page 6 receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement goals and strategies to address client needs for one of seven clients (#1). The findings are: Review on 09/21/22 of client #1's record revealed: -15 year old male. -Admission date of 09/16/20. -Diagnoses of Oppositional Defiant Disorder and Attention Deficit Hyperactivity Disorder, combined presentation. -Treatment Plan dated 09/08/22.	V 112		

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		A. BUILDING: _____	

V 112	Continued From page 7 -No goals or strategies to address client #1's inappropriate sexual behaviors. No goals or strategies addressing the level of monitoring the facility implemented during the last onsite survey on 08/10/22 which was close monitoring and a staff by his door at night due to inappropriate sexual behaviors. Review on 09/21/22 of a Complete Evaluation/Intake dated 09/16/22 for client #1 revealed: "-07/24/22-Client had an incident where he was not in his room, he was in another clients room. On 07/25/22 QP (Qualified Professional) completed a report on [Client #1]. When QP came in the morning staff reported that [Client #1] went into another consumers' room but ensure QP that nothing happened. When QP asked the other consumer that was involved what happened the consumer stated that [Client #1] touched him and was inappropriate with him." Review on 09/20/22 of a North Carolina Incident Response Improvement System (IRIS) for client #1 revealed: - Provider Comments: "Consumer went into another consumer room stated that he was just hiding in the room. When staff talked to the other consumer that is when the consumer stated that [Client #1] 'touched him and stuck his penis into his butt'. - "Describe the cause of this incident, (the details of what led to this incident). Consumer went into another consumer room stated that he was just hiding in the room. When staff talked to the other consumer that is when the consumer stated that [Client #1] 'touched him and stuck his penis into his butt'." During interview on 09/20/22 client #1 revealed:	V 112		

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V 112	Continued From page 8 -The staff sat in the hallway at night when everyone was in the bed. During interview on 09/22/22 the Program Manager revealed: -Client #1's information about inappropriate sexual behaviors was updated on his evaluation. -The information never got updated on the Person-Centered Plan (PCP) for the level of supervision and the inappropriate sexualized behaviors. -The Former QP #1 was supposed to have updated the PCP. -"I'm not going to lie to you it has not been updated."	V 112		
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.	V 132		

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V 132	Continued From page 9 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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that the Health Care Personnel Registry (HCPR) is notified of all allegations against health care personnel, failed to investigate to determine what staff were involved, therefore no protections were put in place to protect the clients during the investigation and failed to investigate allegations of abuse. The findings are: Review on 09/21/22 of client #2's record revealed: -14-year-old male. -Admission date of 03/05/22. -Diagnoses of Post-Traumatic Stress Disorder, Oppositional Defiant Disorder with Disturbance of Conduct.	V 132		

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V 132	Continued From page 10 Review on 09/20/22 of a North Carolina Incident Response Improvement System (IRIS) report for client #2 revealed: - Completed by former Qualified Professional (QP) #1. - Date of incident: 08/17/22 - Date provider learned of the incident: 08/19/22. - No time of incident documented. - Incident Comments: "Client (#2) was showing defiant behaviors and was escorted to his room by staff. Another staff was called to the facility to deal with client. Client reported that staff came into his room beat him up threw him and put him in a hold. Client complain about his arm hurting to other staff that come in on first shift." - No documentation the HCPR was notified of the allegation. Review on 09/20/22 revealed: - No documentation the facility completed an internal investigation of the allegation. Interview on 09/22/22 the Program Director stated: - She had been out on leave from 08/02/22 thru 08/22/22. - She was not notified of an allegation of abuse from client #2. - The former QP #1 was responsible for the IRIS reporting and investigation documentation. This deficiency is cross referenced into 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (V109) for a standard level deficiency and must be corrected within 60 days.	V 132		
V 301	27G .1801 Intensive Res. Tx. Child/Adol - Scope	V 301		

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V 301	Continued From page 11 10A NCAC 27G .1801 SCOPE (a) An intensive residential treatment facility is one that is a 24-hour residential facility that provides a structured living environment within a system of care approach for children or adolescents whose needs require more intensive treatment and supervision than would be available in a residential treatment staff secure facility. (b) It shall not be the primary residence of an individual who is not a client of the facility. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, severe emotional and behavioral disorders or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for acute inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to an intensive integrated treatment setting; and (2) treatment in a locked setting. (e) Services shall be designed to: (1) assist in the development of symptom and behavior management skills; (2) include intensive, frequent and pre-planned crisis management; (3) provide containment and safety from potentially harmful or destructive behaviors; (4) promote involvement in regular productive activity, such as school or work; and (5) support the child or adolescent in gaining the skills needed for reintegration into community living. (f) The intensive residential treatment facility shall coordinate with other individuals and agencies within the child or adolescent's system	V 301		

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V 301	Continued From page 12 of care. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to meet the scope of the license for an intensive residential treatment facility identified to provide intensive treatment and supervision in the residential setting affecting three of seven audited clients (#1, 5 and #7). The findings are: Review on 09/21/22 of the facility's Accident/Incident reports for the month of September 2022 revealed approximately 19 incident reports that all included fights and aggressive behaviors between the clients in the facility. Four of the incidents resulted in hospital encounters due to the aggressive behaviors and injuries resulting from the aggressive behaviors. Finding #1 Review on 09/21/22 of client #1's record revealed: -15 year old male. -Admission date of 09/16/20. -Diagnoses of Oppositional Defiant Disorder and Attention Deficit Hyperactivity Disorder, combined presentation. Review on 09/21/22 of a Complete Evaluation/Intake dated 09/16/22 for client #1 revealed: "-07/24/22-Client had an incident where he was not in his room, he was in another clients room. On 07/25/22 QP (Qualified Professional (Former QP))	V 301		

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V 301	Continued From page 13 completed a report on [Client #1]. When QP (FQP) came in the morning staff reported that [Client #1] went into another consumers' room but ensure QP (FQP) that nothing happened. When QP (FQP) asked the other consumer that was involved what happened the consumer stated that [Client #1] touched him and was inappropriate with him." Review on 09/20/22 of a North Carolina Incident Response Improvement System (IRIS) for client #1 dated 07/25/22 at 1:30am revealed: - Provider Comments: "Consumer (client #1) went into another consumer room stated that he was just hiding in the room. When staff talked to the other consumer that is when the consumer stated that [Client #1] 'touched him and stuck his penis into his butt'. - Describe the cause of this incident, (the details of what led to this incident). Consumer went into another consumer room stated that he was just hiding in the room. When staff talked to the other consumer that is when the consumer stated that [Client #1] 'touched him and stuck his penis into his butt'. - Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. Consumer will have someone sitting at his door every night also there will be someone with him throughout the day." Review on 09/20/22 of the facility surveillance video dated 08/18/22 at 3:01am revealed: - Former Staff (FS) #7 and another staff sitting at a smaller table on a computer. The third staff was sitting in a chair watching the TV in the commons area. The fourth staff was a female staff and walked toward the kitchen area of the facility opposite of the clients' bedrooms. The	V 301		

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V 301		V 301		

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clients were in their rooms and no other staff was sitting at the door of client #1 to provide supervision to ensure the client did not leave his room in the middle of the night.

During interview on 09/20/22 client #1 revealed:
-A staff was supposed to sit by his door at night.

During interview on 09/22/22 staff #5 revealed: -
During third shift two staff are supposed to be sitting in the hall at night while the clients are sleeping.
-A staff is supposed to be sitting at client #1's door to make sure that he does not leave his room at night to go into other clients' rooms.

Interview on 09/21/22 the House Manager stated:
-There should be staff in the hallway at night. -
Staff should be monitoring and supervising the clients on the overnight hours.

Finding #2:
Review on 09/20/22 of client #5's record revealed:
-17-year-old male.
-Admission date of 03/22/22.
-Diagnoses of Major Depressive Disorder, Recurrent Severe with Psychotic Features, Post Traumatic Stress Disorder, Oppositional Defiant Disorder and Unspecified Anxiety Disorder.

Review on 09/21/22 of the facility Accident/Incident report for client #5 dated 09/10/22 with no time specified revealed:
"-Saturday afternoon [Former Client (FC)#8] was refussing with [Client #5] the next thing I saw was [Client #5] hitting [FC #8]. When I got down the room [FC #8] had [Client #5] down on the bed. And he ([FC #8]) was beaten with his fist. With a little investion [Former Staff (FS) #6] found a

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V 301		V 301		

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brush in a sock. [FS #6] question [FC #8] and he said that he hit [Client #5] with the brush. But we was for staff that he was going to hit with the brush."

Review on 09/22/22 of the After Visit Summary for client #5 from the hospital dated 09/10/22 revealed:
"-Diagnoses: Facial Injury, Initial encounter. Abrasion of face, initial encounter."

Interview on 09/20/22 client #5 stated:
-He was 17 years old and admitted to the facility on 03/22/22.
-He had recently been to the hospital due to being in a fight with FC #8.
-The staff were trying to calm down another client.
-The client had put a brush in a sock and hit him with it.
-He had bumps on his head and a "busted lip" and his braces were broken from FC #8.
-FC #8 swung 3 times at him.
-The incident lasted about 10 seconds.

Interview on 09/21/22 staff #1 stated:
-He had been rehired in February 2022 and worked various shifts at the facility.
-He recalled the incident when client #5 was injured.
-He had worked 1st shift and the staff for 2nd shift did not show up.
-"We were short staff."
-2 people from first shift had to leave.
-He called former Qualified Professional (FQP) #1 and FQP #2 and received no answer from either one.
-He called the Program Director and she

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V 301	Continued From page 16 requested him to stay at the facility. -We had 3 staff on shift. -Another issue was going on with other clients when client #5 was attacked and hit by FC #8 with the brush inside the sock. Finding #3: Review on 09/21/22 of client #7's record revealed: -15 year old male. -Admission date of 09/08/22. -Diagnoses of Attention Deficit Hyperactivity Disorder, Post Traumatic Stress Disorder, Mild Intellectual Disability, Developmental Disorder of Speech and Language and Phonological Disorder. Review on 09/21/22 of the facility Accident/Incident report dated 09/12/22 at 7:15pm revealed: "-Narrative: Around 7:15pm [Client #7] was intigating a fight with [Former Client (FC) #9] and a fight began. Staff rastrained [FC #9] and took [Client #7] to his room. About 20 min (minutes) later while dealing with another incident [FC #9] snuck into [Client #7's] room and I ran into stop it. I jumped on top of [Client #7] to block [FC #9's] hits and [Client #7] was ok as far as I could tell. GHM (Group Home Manager) was contacted." Review on 09/22/22 of the After Visit Summary for client #7 from the hospital dated 09/13/22 revealed: -"Diagnoses: Head Injury." Interview on 09/20/22 client #7 stated: -He was 15 years old. -He had resided at the facility for 8 months. -He was in a single bedroom. -2 clients jumped him in his room.	V 301		

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V 301	Continued From page 17 -The staff were down the hallway. -He went to the hospital. -His glasses were broken. Interview on 09/20/22 client #4 stated: -He was 11 years old. -He had been in a fight with client #6 and staff had to separate them. -"2nd shift was chaos." -There was normally 3 or 4 staff on 2nd shift. -There are fights on 2nd shift and staff cannot handle all of them. Interview on 09/22/22 staff #12 stated: -He recalled the incident when client #7 was in an altercation with FC #9 and client #1. -Client #7 and FC #9 had an incident earlier during the day. -Multiple behaviors were going on at the facility in the afternoon. -FC #9 and client #1 decided to "jump him (client #7)." -Staff responded to the incident immediately. -The entire situation lasted about 5 minutes. -He did not see any injury to client #7. Attempts to interview staff #13 on 09/22/22 were unsuccessful and no ability to leave a voice message for a return call. Interview on 09/20/22 and 09/27/22 a local Department of Social Services representative stated: -He was concerned for the overall safety and supervision of the clients at the facility. -The administrative staff did not seem to take responsibility for the actions at the facility. Interview on 09/20/22 and 09/27/22 a local police officer stated he was concerned about the lack of	V 301		

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V 301	Continued From page 18 supervision of clients and the many incidents at the facility. Review on 09/22/22 of a "Plan of Protection" signed by the QP and dated 09/22/22 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? The facility will ensure the safety for all clients in the care of the facility. QP will make sure the facility provides a structure living environment for the who needs require more intensive treatment and supervision by in servicing and training staff. Staff will be trained on PCP's, how to de-escalate a behavior, documentation, PCP goals and how to implement intervention goals for each behavior. How to report harm, abuse, neglect and exploitation and retrain on CPI interventions and how to de-escalate." -"Describe your plans to make sure the above happens. QP will make sure all PCP's of each client is develop with behavior management skills. QP will assist with development of crisis plan and make sure all goals are updated to meet the needs of the client's behavior. QP will ensure he/she is on the premises 75% of the time the clients are awake to make sure clients from potentially harmful or destructive behaviors." Clients #1, #5 and client #7 were 17 and 15 year old males with diagnoses to include Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Depressive Disorder, Mild Intellectual Disability and Post Traumatic Stress Disorder. Client #1 had previously sexually assaulted another client in the facility. The facility had implemented the staff would sit by client #1's door at night to make sure client #1 did not leave his room and try to enter other client bedrooms.	V 301		

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V 301	Continued From page 19 Video surveillance showed on the night of 08/18/22 the staff had not provided the supervision the facility had put in place to ensure client #1 did not leave his room during the night. Due to the lack of supervision by the staff, client #5 and client #7 were attacked by other clients in the facility which caused both clients to sustain injuries including head injuries and broken braces which required medical care by a hospital. The facility incident reports for the months of August and September 2022 revealed aggressive and harmful behaviors of clients attacking other clients and clients attacking staff in the facility. Through staff and client interviews, staff from each shift did not show up for their shifts or arrived late to their shifts which resulted in the clients not receiving supervision as required. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $6,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for failure to correct within 23 days.	V 301		
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	V 367		

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V 367	Continued From page 20 becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III	V 367		

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V 367	Continued From page 21 incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area;(4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure critical incident reports were submitted to the Local Management Entity	V 367		

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V 367	Continued From page 22 (LME)/Managed Care Organization (MCO) within 72 hours as required. The findings are. Review on 09/20/22 of the North Carolina Incident Response Improvement System (IRIS) website revealed no Level II or Level III incident reports had been submitted to the LME from 08/10/22 thru 09/18/22. Finding #1: Review on 09/20/22 of a North Carolina Incident Response Improvement System (IRIS) report for client #2 revealed: -Completed by Former Qualified Professional (FQP) #1. -Date of incident: 08/17/22 -Date provider learned of the incident: 08/19/22. -No time of incident documented. -Incident Comments: "Client (#2) was showing defiant behaviors and was escorted to his room by staff. Another staff was called to the facility to deal with client. Client reported that staff came into his room beat him up threw him and put him in a hold. Client complain about his arm hurting to other staff that come in on first shift." -No documentation the Health Care Personnel Registry (HCPR) or the local Department of Social Services (DSS) was notified of the allegation.. -No documentation the IRIS report was submitted to the LME/MCO as required. Finding #2: Review on 09/21/22 of the facility Accident/Incident report for client #5 dated 09/10/22 no time specified revealed: "-Saturday afternoon [Former Client (FC)#8] was refussing with [Client #5] the next thing I saw was [Client #5] hitting [FC #8]. When I got down the room [FC #8] had [Client #5] down on the bed.	V 367		

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V 367	Continued From page 23 And he ([FC #8]) was beaten with his fist. With a little investion [Former Staff (FS) #6] found a brush in a sock. [FS #6] question [FC #8] and he said that he hit [Client #5] with the brush. But we was for staff that he was going to hit with the brush." Review on 09/20/22 of a IRIS report for client #5 revealed: -Completed by FQP #1. -Date of incident: 09/10/22. -Time of incident: 5:00pm. -No incident comments documented. -No documentation the IRIS report was submitted to the LME/MCO as required. Finding #3: Review on 09/20/22 of a North Carolina IRIS report for Former Client (FC) #8 revealed: -Completed by FQP #1. -Date of incident: 09/08/22. -Time of incident: 7:30am. -"9/9/2022 Police was called in after the behavior happened." -No incident comments documented. -No documentation the IRIS report was submitted to the LME/MCO as required. Review on 09/21/22 of a facility level I incident report completed by staff #5 revealed: -Date of incident: 09/08/22. -Time of incident: 7:30am. -FC #7 was physically and verbally aggressive. -FC #7 caused property destruction. -FC #7 got into an altercation with client #4. -FC #7 threw water on staff and began cursing. -FC #7 kicked the front door open. -FC #7 had to be restrained and the police were called. -The police had to taze FC #7 and was taken to	V 367		

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V 367	Continued From page 24 the hospital. Finding #4 Review on 09/20/22 of a North Carolina Incident Response Improvement System (IRIS) report for client #2 revealed: -Completed by the former Qualified Professional (FQP) #1. -Date of incident: 08/17/22 -Date provider learned of the incident: 08/19/22. -No time of incident documented. -Incident Comments: "Client (#2) was showing defiant behaviors and was escorted to his room by staff. Another staff was called to the facility to deal with client. Client reported that staff came into his room beat him up threw him and put him in a hold. Client complain about his arm hurting to other staff that come in on first shift." -No documentation the local DSS was notified of the allegation. Interview on 09/22/22 the Program Director stated: -She had been on leave from 08/02/22 thru 08/22/22. -The FQP #1 was responsible for the completion of IRIS reports. -She was not aware the reports were not submitted to IRIS as required. This deficiency is cross referenced into 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (V109) for a standard level deficiency and must be corrected in 60 days.	V 367		

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V 500	Continued From page 25 27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in	V 500		

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V 500	Continued From page 26 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention.	V 500		

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V 500	Continued From page 27 This Rule is not met as evidenced by: Based on record review and interviews, the governing body failed to report an allegation of abuse to the Department of Social Services (DSS) affecting one of seven audited clients (#2). The findings are: Review on 09/21/22 of client #2's record revealed: -14 year old male. -Admission date of 03/05/22. -Diagnoses of Post Traumatic Stress Disorder and Oppositional Defiant Disorder with Disturbance of Conduct. Review on 09/20/22 of a North Carolina Incident Response Improvement System (IRIS) report for client #2 revealed: -Completed by the former Qualified Professional (FQP) #1. -Date of incident: 08/17/22 -Date provider learned of the incident: 08/19/22. -No time of incident documented. -Incident Comments: "Client (#2) was showing defiant behaviors and was escorted to his room by staff. Another staff was called to the facility to deal with client. Client reported that staff came into his room beat him up threw him and put him in a hold. Client complain about his arm hurting to other staff that come in on first shift." -No documentation the local DSS was notified of the allegation. Interview on 09/22/22 the Program Director stated: -She had been out on leave from 08/02/22 thru	V 500		

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V 500	Continued From page 28 08/22/22. -She was not notified of an allegation of abuse from client #2. -The FQP #1 was responsible for the IRIS reporting and notification of the local DSS. This deficiency is cross referenced into 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (V109) for a standard level deficiency and must be corrected within 60 days.	V 500		
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 dismissal of the employee.	V 512		

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V 512	Continued From page 29 This Rule is not met as evidenced by: Based on record reviews and interviews three of ten audited staff (#3, #4 and #5) abused one of seven current clients (#2) and one of two former clients (FC) #9). The findings are: Review on 09/22/22 of staff #3's record revealed: -Hire date of 06/08/22. - Direct Care Staff. Review on 09/22/22 of staff #4's record revealed: -Hire date of 06/08/22. - Direct Care Staff. Review on 09/21/22 of client #2's record revealed: -14 year old male. -Admission date of 03/05/22. -Diagnoses of Post Traumatic Stress Disorder (PTSD) and Oppositional Defiant Disorder (ODD) with Disturbance of Conduct. Review on 09/21/22 of FC #9's record revealed: -15 year old male. -Admission date of 09/10/22. -Discharge date of 09/17/22. -Diagnoses of Attention Deficit Hyperactivity Disorder (ADHD), Conduct Disorder, Disruptive Mood Disorder and Child Physical Abuse. Finding #1 Review on 09/20/22 of the facility video surveillance on 08/17/22 at 20:24:29 (8:24pm) revealed: -Client #2 was wearing a black shirt and black pants and he walked into the medication room and staff #4 also wearing a black shirt and black	V 512		

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V 512	Continued From page 30 pants followed client #2 and puts his hand on client #2's shoulder to try and remove him from the room. Client #2 then walked into the kitchen. Staff #3 was sitting in a chair, Staff #4 and Staff #5 were standing all in the same room and were watching client #2. The three staff then move toward the kitchen and are out of camera site. Within 1 minute the staff came out of the kitchen staff #3 had client #2's right leg and staff #4 had client #2's right arm and carried him down the hall to the bedroom area. Staff #5 was walking with staff #3 and staff #4 while they were carrying client #2 from the kitchen down the hallway. Review on 09/20/22 of a North Carolina Incident Response Improvement System (IRIS) report for client #2 revealed: - Completed by Former Qualified Professional (FQP) #1. - Date of incident: 08/17/22 - Date provider learned of the incident: 08/19/22. - No time of incident documented. - Incident Comments: "Client (#2) was showing defiant behaviors and was escorted to his room by staff. Another staff was called to the facility to deal with client. Client reported that staff came into his room beat him up threw him and put him in a hold. Client complain about his arm hurting to other staff that come in on first shift." -No documentation the report was submitted to IRIS. Review on 09/20/22 of the facility records revealed: -An internal investigation had not been completed as required. During interview on 09/20/22 client #2 revealed: -He had been picked up by his arms and legs by staff. -The staff would “grab your arms and legs and carry you like a dead person.” -The staff had grabbed his legs and arms before	V 512		

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V 512	Continued From page 31 and had taken him to his room. -He did not remember the staff names, or the number of staff involved. Interview on 09/20/22 client #4 stated: -He was 11 years old. -He had seen staff grab client #2 by the hands and legs and place him on his bed. -Client #2 was heavy. -"2nd shift was chaos" Interview on 09/20/22 client #7 stated: -He was 15 years old. -He had resided at the facility for 8 months. -He had seen staff pick clients up by their arms and legs and carry them to the rooms. -"They do everybody like that (pick up by arms and legs)." -He was picked up like that as well but could not recall the specifics. During interview on 09/22/22 staff #5 revealed: -Client #2 went into the kitchen and all the staff tried to restrain him. -Client #2 dropped to the floor and two staff grabbed him and carried him to his room. -We are not supposed to grab them by the arms and legs and try not to do that. -"Sometimes" the staff had to grab them by the arms and legs because there was no other way to get the client. During interview on 09/21/22 staff #3 revealed: -He had to restrain client #2 a "few times." -Client #2 liked to have attention. -"The clients know we are not allowed to grab them on the ground." -He was sure he had to grab his legs or arms because client #2 would kick.	V 512		

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V 512	Continued From page 32 During interview on 09/22/22 the Program Director revealed: -She was the instructor for the CPI (Crisis Prevention Institute) training for the staff at the facility. -Staff had never been trained to grab arms and legs of a client during a restraint. Finding #2 Review on 09/21/22 of Former Client (FC) #9's record revealed: -15 year old male. -Admission date of 09/10/22. -Diagnoses of Attention Deficit Hyperactivity Disorder, Conduct Disorder, Disruptive Mood Disorder and Child Physical Abuse. - Date of discharge 09/17/22. Review on 09/20/22 of the facility's Accident/Incident report dated 09/13/22 at 4:30pm revealed: "-Narrative:...[FC #9] was being loud and I (staff #3) asked him to lower his voice and he called me a b***h and squared up with me. I tried to restrain him he pushed me and I tripped over the chair and hit my head and he punched me. I got up and he continued to try and fight me." Review on 09/20/22 of the facility surveillance video from the 09/13/22 incident revealed: -Staff #3 was sitting in a chair in the commons area of the facility. Staff #8 was standing next to staff #3. FC #9 was sitting in a chair to the right of staff #8. Client #4 was talking to staff #8. Staff #8 walked toward the kitchen area and staff #3 continued to sit in the chair and other clients were walking around in the commons area. Staff #8 walked back to the same area he was standing and continued to talk to consumers. FC #9 stood up from his chair and appeared to be agitated by	V 512		

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V 512	Continued From page 33 his body language. Staff #3 stood from his chair and started to approach FC #9 and another client walked to FC #9 attempting to calm him down. FC #9 walked to staff #3 and staff #3 said something to FC #9. FC #9 jumped toward staff #3. Staff #3 took his right arm and lunged at FC #9 wrapping his arm around FC #9's head. FC #9 was able to turn and push staff #3 against the wall causing him to fall to the floor. FC #9 continued to attack staff #3 while he was on the floor while staff #8 attempted to remove FC #9 from staff #3. Staff #3 then kicked his legs and feet at FC #9 to get him off of him and was able to stand back up. It appeared that staff #3 was saying something to FC #9 which he was very agitated and still trying to fight. FC #9 then took his white shirt off while staff #8 was continuing to keep him from going toward the staff #3. Staff #3 was standing behind other staff and was smiling and laughing. Staff #3 continued to stand behind the other staff while the client was still agitated and wanting to fight. FC #9 was not able to be interviewed at the time of the survey. The location of FC #9 was not able to be determined to complete the interview. During interview on 09/21/22 staff #3 revealed: -He worked 2nd shift from 4:00p-12:00am. -He had to complete several physical restraints while working at the facility. -FC #9 tried to fight him. -He had told FC #9 to turn his music off. -FC #9 went after him and he tried to grab his arm. -FC #9 pushed him and he fell over a chair and hit his head. -He was asked if he wanted to press charges and he did not because FC #9 was "only a kid." -FC #9 "assaulted everyone" in the facility.	V 512		

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V 512	Continued From page 34 Interview on 09/22/22 staff #8 stated: -He had worked at the facility for approximately 3 months. -He had been trained in CPI. -He recalled the incident between FC #9 and staff #3. -FC #9 was singing loudly and he got upset with staff #3. -FC #9 "tackled" staff #3. -Staff #3 and FC #9 fell and he tried to pull FC #9 off. -He did not know if the interaction was appropriate but "CPI did not teach them if a person is full grown." -Older clients are normally restrained with a staff on each side holding an arm. -He did not like to restrain clients and would put his arms out to protect his co-worker. Interview on 09/20/22 and 09/27/22 a local Department of Social Services representative stated: - He was concerned for the overall safety and supervision of the clients at the facility. - The administrative staff did not seem to take responsibility for the actions at the facility. Interview on 09/20/22 and 09/27/22 a local police officer stated: -He was concerned about the lack of supervision of clients and the incidents at the facility. -He was also concerned about the way staff handled client behaviors. Interview on 09/20/22 and 09/21/22 the FQP #2 stated: -He provided the videos to the Program Director and took statements. -He referred all issues to the Program Director for	V 512		

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V 512	Continued From page 35 follow up. During interview on 09/22/22 the Program Director revealed: -She was not aware of a video showing staff #3 attacking FC #9. -FC #9 was sent to the facility for Respite (facility is not licensed for Respite) because they were trying to get him moved to another state. -FC #9 had an ankle monitor when he arrived to the facility that she was not aware of. -She did not know anything about FC #9. -He was sent to the hospital after attacking staff and she would not allow him to come back to help protect the staff and other clients in the facility due to his behaviors. -She had been on medical leave from 08/02/22 thru 08/22/22. Review on 09/22/22 of a "Plan of Protection" signed by the QP and dated 09/22/22 revealed: - "What immediate action will the facility take to ensure the safety of the consumers in your care? Qualified Professional will make sure all staff involved in any harm, abuse, neglect or exploitation towards clients will be taken off shift immediately until investigation is completed. QP will begin the internal investigation by interviewing the involved client. QP will report any type of abuse, neglect, harm or exploitation to appropriate authorities such as NC (North Carolina) DSS (Department of Social Services, NC HCPR (Health Care Personnel Registry, Police, guardians and RN (Registered Nurse). QP will immediately instruct facility manager to take involved client to emergency room to be evaluated. QP will submit report to client to emergency room to be evaluated. QP will submit report to NC IRIS (Incident Response Improvement System) and NC Health Registry within the same day. QP will interview staff that's involved in incident, other staff on shift and the other clients. If any violation has been found will	V 512		

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V 512	Continued From page 36 cause grounds for dismissal of the employee." - Describe your plans to make sure the above happens. QP and facility manage will go to the facility as soon as possible when incident or allegation has been made. QP will have a designated room to start internal investigation. QP will instruct other staff that was not involved in the incident to remove client from the situation and stay with client until appropriate authorities get to the facility. the residential director will oversee to make sure all trainings are completed and implemented as needed. CPI instructor will make sure staff are using the correct holding skills and how to de-escalating behaviors." Client #2 and FC #9 were 14 and 15 years old with diagnoses to include ADHD, ODD with Disturbance of Conduct, PTSD, Conduct Disorder, Disruptive Mood Disorder and Child Physical Abuse. A video reviewed showed staff #2 and staff #4 carried client #2 by his arms and legs down a hallway into the bedroom area. Client #2 reported his arm was hurt in this process. The injury was noted in an incomplete IRIS report dated 08/17/22. Additionally a subsequent video from 09/13/22 showed staff #3 attacked and grabbed FC #9 and place him in a headlock type maneuver as they fell to the floor. The FQP #2 had provided the incidents and information to the Program Director. The Program Director was not informed by the FQP #2 about the multiple incidents of abuse which involved client #2 and FC #9. The facility did not ensure the proper documentation was completed and submitted timely as required to the appropriate agencies nor were internal investigations completed as required. This deficiency constitutes a Type A1 rule violation for serious abuse and must be corrected within 23 days. An	V 512		

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V 512	Continued From page 37 administrative penalty of $6,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 512		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (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 wishes to employ must be approved by	V 536		

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V 536	Continued From page 38 the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training	V 536		

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V 536	Continued From page 39 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 a passing grade on testing in an instructor training program. (3) 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. (4) 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 (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor	V 536		

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V 536	Continued From page 40 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 attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) 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. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on interviews and record reviews 1 of 10 audited current staff (House Manager) failed to demonstrate competency in alternatives to restrictive interventions. The findings are: Review on 09/21/22 of Former Client (FC) #9's record revealed: - 15 year old male. - Admission date of 09/10/22. - Diagnoses of Attention Deficit Hyperactivity Disorder, Conduct Disorder, Disruptive Mood Disorder and Child Physical Abuse. - Date of discharge 09/17/22.	V 536		

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V 536	Continued From page 41 Review on 09/27/22 of the House Manager's personnel file revealed: - Date of hire: 09/09/22. - Crisis Prevention Institute (CPI) completed on 09/10/22. Review on 09/21/22 of the facility's Accident/Incident report dated 09/12/22 at 1:30pm revealed: -"All of the consumers was watching a movie that was not appropriate so [House Manager], the facility manager ask them to change it. [FC #9] started cursing saying 'F this,' 'On crip I will beat your a*s to [House Manager]. [House Manager] asked [FC #9] if he was ok and [FC #9] got even angrier. [FC #9] was told to go to his room to calm down, and when he was ready to talk, that [House Manager] wanted to talk to him. [FC #9] wouldn't stay in his room and was lingering in the hallway. [House Manager] ask [FC #9] to go back in his room. That is when [FC #9] lunged at [House Manager] striking him with a blow to the front left temple before several theraputic staff members interviened to calm him down." Interview on 09/21/22 staff #1 stated: -Rehired in February 2022. -Worked various shifts at the facility. -Was at the facility when FC #9 hit the House Manager. -FC #9 was upset with the House Manager. -FC #9 was being aggressive. -The House Manager had "antagonized" FC #9. He wrote a report. -FC #9 hit the House Manager. -He thought "He (House Manager) deserved it." - He told Former Qualified Professional #2.	V 536		

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Interview on 09/22/22 staff #9 stated:
-Started in January 2021.
-Usually worked on 1st shift 8am to 4pm.
- Recalled the incident between FC #9 and the House Manager.
-He and clients were watching a movie and the House Manager said it was not appropriate.
- The House Manager cut the movie off and FC #9 got upset.
-FC #9 got in the House Manager's face and the clients went to their rooms.
-The House Manager tried repeatedly to talk to FC #9.
-FC #9 told the House Manager not to come to his room.
-The House Manager went to talk to FC #9 and FC #9 swung at him and missed.
-He and staff #1 walked with the House Manager to FC #9's room and FC #9 hit the House Manager.
-"We were taught to avoid clients if triggered."- The House Manager kept trying to talk to FC #9. - He did not think the House Manager should have kept attempting to engage with FC #9 which caused the House Manager to get hit.

Interview on 09/21/22 the House Manager stated:
-Started working at the facility last Monday (09/12/22).
-On his 1st day he got hit by FC #9.
- He had redirected staff and clients about watching inappropriate movies.
-FC #9 got upset and began to threaten him and curse at him.
-He tried to stay away and to not agitate FC #9 further.
-FC #9 swung at him and missed.
-FC #9 went to his room.
-FC #9 did not want to talk.
-He and staff #1 were at FC #9's room.
-FC #9 came out and struck him in the left front

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V 536	Continued From page 43 temple. -The police were called but he did not file charges against FC #9. -Staff #1 and staff #9 were on duty during the incident. Interview on 09/22/22 the Program Manager stated: -She taught Crisis Prevention. -She understood the concern the House Manager continued to engage FC #9 and he got hit. -Staff were going to be retrained in de-escalation.	V 536		