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	MHL059-072	A. BUILDING: _____ B. WING _____	R 11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEAR SKY GROUP HOME	55 RAILROAD STREET MARION, NC 28752

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V 000	INITIAL COMMENTS An annual and follow up survey was completed on November 16, 2022. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G. 1700 Residential Treatment Staff Secure for Children and Adolescents. The facility is licensed for 8 and currently has a census of 8. The survey sample consisted of audits of 3 current clients.	V 000		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for	V 109	Received of Mental Health Licensure & Certification 11-28-22	

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V 109	Continued From page 1 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, 1 of 2 Qualified Professionals, (Behavioral Health Director/Qualified Professional #1 (BHD/QP #1)) failed to demonstrate the knowledge, skills, and abilities required by the population served. The findings are: Review on 10/18/22 of BHD/QP #1's record revealed: -Date of Hire 9/25/17 -Position: Behavioral Health Director/QP Review on 10/20/22 of BHD/QP #1's job description dated 1/24/20 revealed: "Behavioral Health Director (QP) will coordinate and monitor all aspects of the consumer case. This includes monitoring the progress of the person-centered plans ... responding to deficiencies in services and managing the consumer caseload/documentation. The QP will provide administrative support ... and advises the Associate Professional and direct care team members of all consumer support plans/goals	V 109		

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V 109	Continued From page 2	V 109		

and interventions"
"Duties and Responsibilities:
-Conduct initial assessments and intake of new clients;
-Be knowledgeable in the challenges and care of adolescent clients with mental illness;
-Lead the initial and ongoing revisions of the Person Centered Plan (PCP);
-Consult with community agencies and families to maintain coordination of care;
-Provide oversight to the direct care team and ensure staff are completing their duties ..."
"Skills, Knowledge and Abilities:
-have thorough knowledge of rules, regulations, policies and procedures."

Refer to V111 for failure to complete assessments:
-admission assessments did not reflect client treatment needs nor level of care needed during the intake process;
-client treatment needs were not re-assessed when admitted to higher/lower levels of care within their system.

Refer to V112 for failure to develop and implement goals, interventions, and strategies in client Person Centered Plans (PCPs):
-PCPs for Clients #1, #2, and #3 had the same strategies and interventions for all goals;
-PCP goals did not address identified client behaviors for Clients #1, #2, and #3;
-PCPs did not assess clients' ability to be supervised by only one staff.

Refer to V296 for failure to ensure minimum staffing ratios at the facility:
-the facility was observed to be out of ratio on 10/7/22;
-the facility used a single staff to transport

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V 109	Continued From page 3 multiple clients to school and community outings. Refer to V298 for failure to coordinate educational services: -Client #1 was re-admitted to this facility on 9/21/22, did not attend school until 10/17/22, and was discharged on 10/20/22; -the facility failed to coordinate Client #1's enrollment with the school system. Refer to V367 for failure to submit incident reports timely: -Level II incidents were not being submitted within 72 hours as required or reported at all; -this has been cited three times previously. Refer to V536 and V537 for failure to ensure staff were trained in restrictive interventions and alternatives to restrictive interventions prior to providing services: -the facility failed to train all staff in restrictive interventions despite its own policy of approving two therapeutic holds. -Direct Support Professional #2 (DSP #2)'s alternatives to restrictive intervention training had expired. Interviews on 10/13/22 with the BHD/QP #1 revealed: -he oversees the operations side, manages direct care personnel, "bridges the gap with the clinical team", supervises staff, and the intake process; -he completes the initial assessment screening tool for admission and makes the determination for admission; -during the intake process, he would review clinical documentation sent and see if they are appropriate for the program and send it on to the Associate Professional (AP) to review it and former therapist as well;	V 109	This concern is relative to the initial assessment plan that Clear Sky Behavioral, LLC has been using following a survey in 2018. This form and process was approved during this audit but has been modified to meet concerns of this survey team. The question was posed that, “why does our staff clinician not participate in the intake process.” The Clear Sky Behavioral response to this question is that Level 2 facilities typically doesn’t have a staff clinician to utilize. It is relied upon for the QP to make these decisions. The clinical documents many times are tailored to fit the vacant bed from the guardian or previous residential provider. We are getting documentation that reflects the appropriate level of care . Sometimes these children are recently taken into custody and MCOs suggest least restrictive option as the starting point for services. We also have children stepping down after stays in PRTF settings and the MCOs are reducing funding for a trial period. Many times, we get these cases and turn around a level them right back up. These are genuine concerns in this industry. We utilize an “Immediate Liability Form” in an attempt to create automatic declines for Gang activity, Sexualized behaviors, and assaultive behaviors. The initial assessment screening tool form is used to discuss the case with the guardian as an initial step prior to receiving the clinical documents that are shared. This form will sometimes differ from the clinical documents because it is based upon the details provided by the child family team. This process has been revised with slight changes to the form as suggested by the DHSR survey team and also to incorporate a clinical review of documents that utilize a minimum of 6 months lookback. We have also reluctantly added a review by our staff clinician for another layer of approval. This has been discussed during the informal appeal process and awaiting the results of this area of concern.	12/1/2022

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V 109	Continued From page 4 - "the last step is the screening tool ... we want an annual Comprehensive Clinical Assessment (CCA) and psych eval (psychological evaluation)...sometimes we get information after (admissions);" -"has sent the screening tool to guardians prior to admission and more times than not I'm left to fill it out ..." -after admission, we come up with a "canned PCP initially with general goals ... and then we have the first Child and Family Team (CFT) and will develop the PCP more specifically;" -regarding admission of clients, "we try to steer away from kids that have gang activity, physical aggression, and kids that have sexualized behaviors ...but this is the most difficult population and a lot of these kids come with trauma;" -regarding the process of leveling kids down, "its starts with getting reports from direct care staff ...and how long the client has been consistent, talking with the clinician, ... and would present it to the team;" -does not complete another initial assessment when clients are leveled up or down; -"there was a lot of discussion with your counterparts about the intake process ...its changing;" - regarding Client #1 being transitioned to level II after being at this facility for less than 6 weeks.. "he was doing well initially at the level III, stepped him down to level II, he did not do well, and he came back to level III;" -confirmed there was information shared about Client #1's sexualized behavior prior to admission; -"..school for 16 year-olds is different ....they go to the [Adult High School] ... we utilize [Outpatient Plus] services in lieu of day treatment ...with the groups and a direct care staff pulling kids out for individual;"	V 109	This concern was relative to the goals of the PCP not matching the recent incidents or emergency CFT concerns. We were writing longer narratives at the conclusion of the CFT but leaving relative goals in place. Clear Sky Behavioral understands the immediate concern of revising the goals and has amended policy to reflect any trending type incidents and emergency CFT concerns. This process has been put in place company wide. All case management and QPs have been trained of this requirement to change goals and highlight any client specific interventions relative to the client being served. This concern was discussed during the informal appeal process and currently awaiting the findings of this. This concern has developed on several occasions regarding reporting incidents to the IRIS system. It has been noted that the IRIS system is very cumbersome to navigate and very little training opportunities exist to ensure proper utilization of this platform. We have reached out to Vaya and they are working with us to ensure our QPs responsible for submission to IRIS are properly trained in utilization. I have also began requiring screen shots of the “THUMBS UP” icon to ensure that the submission was successfully transmitted in the first place. The IRIS system provides a confirmation number at some point but this still doesn’t constitute that the submission went through completely. This was an issue that was overlooked by administration because of reviewing the case file revealed a screenshot of the confirmation but not the “thumbs up” icon. This expectation and submission of the IRIS within 72 hours of the incident is currently in place.	12/1/2022 12/1/2022

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V 109	Continued From page 5 -prior to September 2022, he did the incident reports for the facility and put them in North Carolina Incident Response Improvement System (IRIS); -he now has someone helping him input incident reports that works at a sister facility; -regarding maintenance, he does drop-ins at facilities as needed, "...have a maintenance guy on staff;" -not all the staff were trained in restraint "...I don't have a staff list in front of me ...the worry is with the younger kids." This deficiency constitutes a recited deficiency and is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 109		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this 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;	V 110		

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V 110	Continued From page 6 (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, 1 of 4 audited Paraprofessionals (Operations Director/Behavioral Health facilitator (OD/BHF)) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are: Review on 10/24/22 of the OD/BHF's record revealed: -Date of Hire: 5/22/19 -Position: OD/BHF. Review on 10/20/22 of OD/BHF's job description signed and dated 1/30/20 revealed: "Summary of Position: - ...The BH-F is in charge of facilitating the flow of the treatment facility to ensure each day runs smoothly and the daily agenda is completed. The BH-F will work in collaboration with the administrative team and direct care staff to ensure the mission base of the company are met and the residents are working towards the	V 110		

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V 110	Continued From page 7 successful completion of the program. "Duties and responsibilities: -Coordinate with company Behavioral Health Specialists to establish and implement goals to ensure that the daily functions of the treatment program are successfully completed and are in compliance with rules and regulations of the governing bodies -Monitor building interior and exterior for cleanliness and safety issues ... -Work with Behavioral Health Specialist to ensure proper to resident to staff ratio is maintained in the event of an employee call-in or no show ... -provide and maintain a safe environment for all residents ... -Follow the Person Center Plan (PCP) and offer input with changes that may be required ... -Monitor physical and emotional well-being of residents and report unusual behavior or physical ailments to BH-Supervisor ..." Refer to V112 for failure to implement treatment planning for Client's #1, #2, and #3; -failed to follow the Person Centered Plan and offer input with the changes that may be required; -failed to coordinate with direct care staff regarding the safety and supervision needs of Client #1 as recommended by the therapist; -failed to establish and implement goals for clients to ensure daily functions of the treatment program were completed and in accordance with rules and regulations. Refer to V296 for minimum staffing requirements: -failed to ensure the minimum staffing requirements were met for the facility; Refer to V736 for failure to monitor the condition of the facility.	V 110	This concern was relative to the goals of the PCP not matching the recent incidents or emergency CFT concerns. We were writing longer narratives at the conclusion of the CFT but leaving relative goals in place. Clear Sky Behavioral understands the immediate concern of revising the goals and has amended policy to reflect any trending type incidents and emergency CFT concerns. This process has been put in place company wide. All case management and QPs have been trained of this requirement to change goals and highlight any client specific interventions relative to the client being served. This concern was discussed during the informal appeal process and currently awaiting the findings of this.	12/1/2022

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V 110	Continued From page 8 Review on 10/13/22 of the Comprehensive Clinical Assessment (CCA) addendum completed on 9/14/22 by the Therapist revealed: -on 9/12/22, Client #1 accepted drugs from a stranger while on an outing ...his behavior was erratic in the evening, stated he was having hallucinations; tested positive for benzodiazepines the next morning. The facility issued a 30-day discharge notice to the guardian. He was immediately moved to the Level 3 facility, for "his safety," pending approval for immediate Level III placement and locating a PRTF (Psychiatric Residential Treatment Facility). "He will be an 'eyes on' client for the remainder of his stay at CSB (Clear Sky Behavioral-licensee), being escorted to the restroom and shower, sleeping in a separate area with a staff member nearby. The potential for this client to act in a sexually assaultive manner is high. He has been 'consensually' sexually active since age 9 and has a history of threatening others with sexual assault." Interview on 10/14/22 with the Therapist revealed: -"eyes on" meant "someone is watching that kid ...24/7 line of sight...even at night that would be line of sight;" -she had only used "eyes on" one time when there was a resident diagnosed with schizophrenia; -Client #1 was moved from the Level II sister facility to this facility "because of his behavior...he was destructive...has a history of problem sexualized behavior;" -regarding when Client #1 was taken off the eyes on protocol "I'm not daily in the house ...I can tell you he's monitored very closely...I can only make recommendations...not sure what goes on in the house ...that's [OD/BHF's] purview" .	V 110		

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V 110	Continued From page 9 -"we re-assess every week; he struggles with sexual urges, impulse control ..." Interviews on 10/11/22, 10/14/22 and 10/24/22 with the OD/BHF revealed: -she supervised the direct care staff; -her facilitator role was to "make sure everything moves smoothly;" -"I'm the crisis person;" -Client #1 was "eyes on ....we did that for the first couple of weeks" then the Therapist re-assessed Client #1 and he no longer needed eyes on; -she communicated "eyes on" needs to night staff; -Client #1 now had 15 minute bed checks; he "likes to poke and prod ...and that's it." -she "communicated with [Therapist] every single day;" -there was a staff meeting today about Client #1 and Client #5 and they will be making room changes; "when starting moving rooms, kids get wound up;" -for safety planning about client behaviors, "you would have to ask [Therapist]." Review on 10/14/22 of Awake Overnight Progress Notes from 9/19/22-10/12/22 for Client #1 revealed: -the schedule and frequency to conduct an "eyes on" bed check was hourly; -a bed check was documented hourly from 7:00pm to 7:00am; -there was no documentation of bed checks for 9/22/22, 9/23/22, and 9/30/22. Interview on 10/11/22 with Client #1 revealed: -Client #5 was his roommate; he doesn't like being his roommate because Client #5 "gets too angry ...wants to fight, he gets aggressive...masturbates" when he is in the room	V 110	Clear Sky Behavioral, LLC has incorporated a crisis response on-call policy that will rotate the responsibility between our clinical staff. The clinical on-call response can be completed by Licensed Clinicians, Qualified Professionals, and Peer Support personnel. The on-call period will extend for periods outside of normal office hours and will typically consist of weekends and holidays. This corrective action will be implemented by 12/1/2022. The daily shift notes for the night shift were misfiled and not provided to the survey team as evidence of the bed checks being conducted. We utilize THERAP as a new electronic record management program for us and when we download notes to a single file it will only capture the ones filed correctly. Some staff are still learning the program and categorize the notes in the wrong folders. The notes have been recovered and are available for review.	12/1/2022

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V 110	Continued From page 10 sleeping; -he told the OD/BHF 3-4 days ago about his concern about Client #5 but nothing happened after he told them; -he requested to sleep in the living room because of what was happening with his roommate. Interview on 10/11/22 with Client #3 revealed: -he and another client tattooed themselves; it took a couple of days to do the tattoo; -the OD/BHF talked to him about the tattoo; -he thought it was infected and he told staff; he had been asking to see a doctor for the tattoo and "they say ok but never did it." Interview on 10/13/22 with BHD/QP #1 revealed: -"eyes on" meant for a client to put their mattress in the multi-purpose room; there were staff in the office (who can see the multi-purpose room via camera); -he had "guidance from Disability Rights on that process to meet their needs as well." Interview on 10/17/22 with Direct Support Professional #3 (DSP #3) revealed: -"eyes on" was "I believe that's when you ...I'm trying to I think ...that is like, where they have to be watched intently;" -he thought it had been used when "one of them threatened another;" -he had not been asked specifically to do "eyes on" with any clients. Interview on 10/24/22 with the Associate Professional (AP) revealed: -bed checks were done every 30 minutes to one hour; -if a client had escalated behavior, the "clinician (therapist) might recommend 15 minute bed checks;"	V 110	Client requested to sleep in the living room. This was not mandated. We have shared bed rooms and room assignments change regularly. The problem, at times, is the resident has been to every room and the same issues present themselves or clients don't want to move due to being stable and happy with their current roommate. All residents were seen regarding the tattooing incident. They were either seen in person or via telehealth with instructions to put Neosporin on it. This concern was never discussed by the surveyor or Clear Sky Behavioral given an opportunity to provide rebuttal or documentation to support that the resident was treated medically for this. This concern was discussed for matters that required continual supervision concerns. We stated that a lot can happen in a 30 minute period of time between bed checks and we needed a practice that would allow 8 hours of uninterrupted sleep while still maintaining safety with the client. This is a rare occurrence but sometimes seems to be needed for best practice. Reference point would be Kirby Morrow at disability rights.	

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V 110	Continued From page 11 -she was not aware if the therapist had made any recent recommendations for 15 minute bed checks; -when Client #1 returned to the Level III facility, "did eyes on." This deficiency is cross referenced into 10A NCAC .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 110	Policy will be revised to be 30 minutes intervals with no frequency changes. We have done 1 hour for years but it feels as though the intervals of bed checks are becoming an area of confusion. We will revise the policy and the intervals will be 30 minutes or "eyes on" in accordance with Disability rights. There is no reason to need a 15 minute interval. 30 minute is the normal and "eyes on" will be the crisis planned interval. This will be effective December 1, 2022.	12/1/2022
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.	V 111		

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	MHL059-072	A. BUILDING: _____ B. WING _____	R 11/16/2022

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to have an assessment that accurately reflected the presenting problems and needs of the clients affecting 2 of 3 current clients (Client #1 and Client #3). The findings are:

Review on 10/12/22 of Client #1's record revealed:
-Admission Date: 7/14/22;
-Transfer to level II sister facility on 8/26/22;
-Re-Admission to this facility on 9/21/22;
-Age:16;
-Diagnoses: Conduct Disorder (D/O), Disruptive Mood Dysregulation D/O, Unspecified Trauma D/O; Borderline Intellectual Functioning and Encounter for Mental Health Services for Perpetrator of Non-Parental Sexual Abuse;
-Long Range Goal on Person Centered Plan (PCP) dated 7/25/22, "For me to go to school ...to get my high school diploma"

Interview on 10/24/22 with Qualified Professional #2 revealed:
Client #1 was discharged on Thursday (10/20/22).

Review on 10/13/22 of the Comprehensive Clinical Assessment (CCA) dated 4/20/22 by the previous Level III facility revealed:

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V 111	Continued From page 13 -Client #1 was placed at the facility for "problematic sexual behavior" by his guardian; -had a history of "significant behavioral issues and inappropriate sexual behaviors, including sexually victimizing several family members, telling residents of a group home that he would rape them, and engaging in mutual sexual activity with a peer while in a group home" -also had a "history of physical aggression, running away, stealing, property destruction, truancy, and purging after eating" -previous treatment at a PRTF (Psychiatric Residential Treatment Facility) program for sexual harm behavior September 2021 until admission to previous Level III facility; two additional group home placements and hospitalized for self-injury; -history of neglect and physical neglect; history of suicidal ideation and self-injury; history of legal charges including simple assault, injury to personal property and resisting public officer; -this was his fourth residential placement; -recommendation for Client #1 to remain in "Level III placement until discharge goals are met and he can be safely managed in the community." Review on 10/13/22 of a CCA addendum dated 6/7/22 completed by previous Level III facility revealed: -behavior had been inconsistent since admission on 11/21/21; -behaviors were escalating rather than showing any positive response after 7 months in treatment; behaviors have "escalated significantly over the month +;" -was in 5 therapeutic restraints since 5/8/22 for behaviors which included physical aggression to staff, sharpening a knife and refusing to put it down, throwing rocks and sticks at staff and hitting staff in the head with a rock;	V 111		

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-5/30/22- evaluated at the hospital after eating wild mushrooms; return to the facility after the evaluation;
-5/31/22- therapeutically restrained after attempting to pick/eat wild mushroom and animal matter from the ground;
-6/2/22- involuntarily committed due to suicidal ideation and attempt to eat wild mushrooms;
-Recommendations:
-it was "very strongly recommended" that Client #1 transition to a PRTF setting "as his attempts to self-harm are too high a risk to be assumed by a Residential Level III program."

Review on 10/13/22 of a CCA addendum dated 7/20/22 completed by previous Level III facility revealed:
-Client #1's behaviors had been inconsistent since his admission on 11/12/21; had been in 10 therapeutic restraints since 5/8/22
-Recommendations:
-transition to another Level III program with Outpatient Plus Therapeutic Services where he can address his frequent behavior outbursts in a smaller setting.

Review on 10/13/22 of the facility's Initial Assessment Screening Tool for Client #1's admission dated 7/13/22 revealed:
-"NO" to does candidate have history of physical aggression towards staff?
-"YES", challenges with peers to does candidate have behavioral concerns at school or during peer interactions?
-"YES" to does candidate have any sexualized behaviors? Comment: Current Level 3 placement is "requesting a move due to not responding;"
-"YES, defiant" to does candidate have issues with staff prompts and accepting guidance?

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-"NO" to does candidate have a history of suicidal threats or gestures?
-signed by BHD/QP #1 on 7/13/22;
-QP comments: "Information collected from case worker. Client is being discharged from [Level III placement] due to not meeting program expectations. Client is being placed with CSB (Clear Sky Behavioral) on temporary contract due to discharge ....CSB will evaluate client on contract and will assess prior to seeking authorization."

Review on 10/17/22 of Client #3's record revealed:
-Admission to this facility: 9/6/22
-Age:15
-Diagnoses: Post Traumatic Stress Disorder (D/O), Disruptive Mood Dysregulation D/O, and Attention Deficit Hyperactivity Disorder (ADHD);
Comprehensive Clinical Assessment (CCA) dated 7/13/21 that noted a history of childhood neglect, physical/sexual abuse, threatening suicide, delusional thinking, multiple hospitalizations for Suicidal Ideation/Homicidal Ideation (SI/HI) in 2020, peer relational problems, low Intelligence Quotient (IQ) of 67, behavior that is consistent with Autism, aggression, school problems, and an Individual Education Plan (IEP);
-CCA addendum dated 8/17/22 noted that Client #3 had begun to elope from his level III placement and recommended "a lateral level III placement ... displayed significant intellectual disabilities that require a different level of care at this time"

Review on 10/17/22 of the facility's Initial Assessment Screening Tool for Client #3's admission dated 8/10/22 revealed:
-"YES" to does candidate have any behavioral concerns at school or during peer interaction?

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-"NO" to does candidate have a history of suicidal threats or gestures;
-"NO" to does candidate have a history of homicidal threats, gestures;
-"NO" to does candidate have a cognitive disability;
-"NO" to does candidate have an Individualized Education Plan (IEP);
-"YES" to is candidate capable of learning at the current grade level? IQ on record?
-signed by BHD/QP#1 on 8/10/22;
-"QP comments: Guardian wishes for client to enter Level III program and transition to Level II program...Client is accepted into level III program and awaiting a bed."

Interview on 10/13/22 with BHD/QP #1 revealed:
-Client #1 came from another level III facility; "he was a smaller kid ...getting bullied ...was just not a good program for him;"
-was admitted to the facility on a contract "to see if we could manage him at level III;"
-Client #1 was stepped down to the level II facility on 8/26/22, but "he did not do well;" he was re-admitted to Level III on 9/21/22;
-when he was re-admitted to level III, that's when "we found out about the dare incident;"
-Client #3 came from another level III... "tends to be a follower ...easily influenced;"
-"had not seen any major behavioral issues ...struggling with virtual school right now;"
-he had the therapist talk to Client #3 about tattooing and drawing on himself;
-"[Client #2] is involved with Disability Rights ...if it's in his brain ...he's going to do it ...impulsive kid."

Interview on 10/14/22 with the Therapist revealed:
-Client #3 does have a history of self-harm and "it wasn't in any of the pre-admission docs

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(documents)..."
-"[Client #3] ...definitely has her attention;"
-Management has recognized the need for her to be involved in the admissions process.

Interview on 10/13/22 with Client #1 and #3's guardian revealed:
-regarding presenting concerns for Client #1, she reported "low IQ, inappropriate sexual boundaries and inappropriate behaviors when he gets mad;"
-"[Client #1] was going to be moved from the facility in about a month for his own protection and everyone else's;"
-Client #3 had been there since 9/6/22 "...he has been doing good ...he does honeymoon in the beginning;"
-she was aware of Client #3 getting a tattoo and "cheeking" his medication.

Interview on 10/24/22 with the Associate Professional revealed:
-"[Client #3] came on as a temporary placement ...wasn't a lot of clinical documentation ...he was admitted here and a couple of days later we put him down at level II;"
-the guardian called and said "I've got to go pick him up right now."

Review on 10/12/22 of Admission Logs to the facility revealed:
Client #3 was not on the admission log of the facility.

Interview on 10/12/22 with the Administrator revealed:
-"process for intake is changing...for last four years, [BHD/QP#1] has done them solely;"
-"...making modification to the assessment tool...clinical will review documents for more than the last month;"

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V 111	Continued From page 18 -"...the provider calls and asks what they have available and then adjusts the addendum to reflect the level available" -asked, "at what point were the clinicians held accountable?" -typically, they will get a 30-day CCA addendum that will recommend what bed (level) they have available; -"[BHD/QP#1] 100% admitted [Client #1];" -he was going to create an admissions committee; -he was already making changes with this process. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days	V 111	This concern is relative to the initial assessment plan that Clear Sky Behavioral, LLC has been using following a survey in 2018. This form and process was approved during this audit but has been modified to meet concerns of this survey team. The question was posed that, "why does our staff clinician not participate in the intake process." The Clear Sky Behavioral response to this question is that Level 2 facilities typically doesn't have a staff clinician to utilize. It is relied upon for the QP to make these decisions. The clinical documents many times are tailored to fit the vacant bed from the guardian or previous residential provider. We are getting documentation that reflects the appropriate level of care . Sometimes these children are recently taken into custody and MCOs suggest least restrictive option as the starting point for services. We also have children stepping down after stays in PRTF settings and the MCOs are reducing funding for a trial period. Many times, we get these cases and turn around a level them right back up. These are genuine concerns in this industry. We utilize an "Immediate Liability Form" in an attempt to create automatic declines for Gang activity, Sexualized behaviors, and assaultive behaviors. The initial assessment screening tool form is used to discuss the case with the guardian as an initial step prior to receiving the clinical documents that are shared. This form will sometimes differ from the clinical documents because it is based upon the details provided by the child family team. This process has been revised with slight changes to the form as suggested by the DHSR survey team and also to incorporate a clinical review of documents that utilize a minimum of 6 months lookback. We have also reluctantly added a review by our staff clinician for another layer of approval. This has been discussed during the informal appeal process and awaiting the results of this area of concern.	12/1/2022
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be 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;	V 112		

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V 112	Continued From page 19 (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 the treatment needs of 3 of 3 audited clients (Clients #1, Client #2, and Client #3). The findings are: Review on 10/12/22 of Client #1's record revealed: -Admission Date: 7/14/22; -Transfered to Level II sister facility on 8/26/22; -Re-Admitted to Level III facility on 9/21/22; -Age:16; -Diagnoses: Conduct Disorder (D/O), Disruptive Mood Dysregulation D/O (DMDD), Unspecified Trauma D/O; Borderline Intellectual Functioning and Encounter for Mental Health Services for Perpetrator of Non Parental Sexual Abuse; -Long Range Goal on Person Centered Plan (PCP) dated 7/25/22, "For me to go to school ...to get my high school diploma." Interview on 10/24/22 with Qualifed Professional (QP) #2 revealed:	V 112		

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V 112	Continued From page 20 -Client #1 "was discharged on Thursday" (10/20/22)." Review on 10/19/22 of Facility Daily Notes from 8/1/22 to 8/25/22 and 9/16/22 to 10/9/22 for Client #1 revealed: -8/5/22: crawled out of his window in the morning; got into an argument with peers that were caught doing tattoos, admitted to staff he made the tattoo tool for the peers; -8/10/22: sprayed Clorox cleaning spray all over dining room for no reason and laughed about it; -9/16/22: was heard by staff making a vulgar remark to a peer about the peer's mother; denied he said it and did not participate in chores; -9/17/22 and 9/18/22: needed reminders to ask before crossing the facility lines (on the floor); -9/19/22- yelled an accusation at a peer that the peer put something on his glasses cleaning cloth; ignored staff's prompts and called staff liars; -9/20/22-became upset at a peer, tried to get the peer to fight and ignored staff. Police were called as a "safety measure due to [Client #1] refusing to return to the facility and for trying to fight another peer;" 9/22/22: unable to follow facility rules; "antagonized other residents and prodded a peer until the peer reacted with violence;" 9/26/22: another client informed staff that Client #1 went into his room and it was making him uncomfortable; 9/27/22: began shoving things into the vending machine to get change and began cursing at staff when prompted to stop; 9/28/22: "was climbing facility walls, yelling and running around facility;" did not listen to staff to stop; 10/3/22: was "fiddling" with arcade game; later had parts of the machine in his hands; eventually began banging his head on the machine.	V 112		

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V 112	Continued From page 21 Review on 10/19/22 of the Therapist's Clinical Report Notes notes for Client #1 from 8/1/22 to 10/14/22 revealed: -9/13/22- admitted to having sexual contact with 2 different residents; -9/21/22- the therapist reviewed notes from the previous Level 3 program; the Therapist noted that Client #1 had a significant history of sexual acting out "that complicates his work in the area of respecting the boundaries of others. "Developed plan to address inappropriate sexual remarks and actions ...still struggling with making inappropriate sexual comments;" -9/26/22-still being reported for making sexual comments to peers; struggles to gain insight ...does not believe his behaviors are negative or wrong; 9/26/22-completed a program for sexual harm but does not "tie what he learned with his current behaviors;" 10/11/22-completed a program for problem sexual behaviors; he can't verbalize why his behaviors were problematic. Review on 10/12/22 and 10/13/22 of Client #1's Person Centered Plan (PCP) dated 7/25/22 and revised on 8/16/22, 8/24/22, 9/19/22, and 9/22/22 revealed the following goals: 1. accept and follow the guidance of staff members in the facility setting by following the facility rules and utilizing staff as support. -Revised: 8/19/2022- learn effective transitional living skills to prepare him for adulthood: -Have positive interactions with staff and peers -Remain tactful to others during uncomfortable social situations -Utilize staff as support 2. attend and complete his assignments with passing grades during the academic day ...be	V 112		

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respectful to staff and instructors ...complete his daily journal, Bridge Assignments, hygiene, and chores.
3. increase his life skills and ability to function outside of a Residential group home by focusing on "staying in his lane" and not getting caught up in negative behaviors.
Revised: 8/19/2022: develop and utilize skills to reduce anger and manage mood swings throughout the day:
-Participate in therapy to learn emotion management and coping skills to utilize throughout the day
-Accept feedback from staff, including "no", without arguing.
-not put himself in dangerous situations by "pressing the buttons" of others that may react irrationally to his gestures
-Support/interventions on the PCP were the same for every goal;
-there were no goals, interventions or strategies to address client's sexualized behavior/sexual acting out, physical aggression, or suicidal ideation and self-harm;
-there was no documentation to support Client #1's unsupervised time allowing 1:1 transportation by staff or walks with the Peer Support Specialist (PSS).

Review on 10/17/22 of Client #2's record revealed:
-Date of Admission: 6/22/22;
-Age:17
-Diagnoses: Post Traumatic Stress Disorder (PTSD), DMDD, Attention Deficit Hyperactivity Disorder, (ADHD) and Static Encephalopathy;
-Comprehensive Clinical Assessment (CCA) dated 2/24/22 noted history of early childhood trauma, physical/sexual abuse, neglect, adoption, verbal/physical aggression, prior attachment

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disorder diagnoses, physical violence towards parents, school difficulties, low IQ, elopement, property destruction, and impulsivity;
-history of law enforcement response with crisis and discharge;
-lengthy residential treatment history and aggression as the symptomology being treated;
-concern that Client #2 has Fetal Alcohol Spectrum D/O (FASD);
2/24/22 CCA recommended: "Psychiatric Residential Treatment Facility is recommended at this time due to high intensity aggression, occasional elopement and theft ...has engaged in lower levels of care and additionally has been hospitalized on multiple occasions."

Review on 10/17/22 of Client #2's updated CCA Addendum dated 6/20/22 revealed:
-"[Client #2] has displayed significant difficulties with his current Level 3 placement with him going AWOL for the first day of placement and continued failure to comply with staff's directions ...He continuously stated to staff and [local law enforcement] that he wants to move to another facility, and he will continue to go Absence Without Official Leave (AWOL) until he is moved to [current level III placement] ...Based on current behaviors, the team agreed."

Review on 10/18/22 and 10/19/22 of Facility Daily Notes from 8/1/22 to 10/14/22 for Client #2 revealed:
-8/5/22: he started a fight with a peer and had to be separated;
-8/7/22: verbal aggression, going in other client rooms; ... "it was discovered that he had given himself multiple stick and poke tattoos;"
-8/8/22: after being re-directed and prompted by staff multiple times, "came into the office ...grabbed another peer by the neck and punched

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him in the face;"
-8/17/22: "inappropriate language throughout day, ...he stole a pair head phones from school, became upset and walked out of facility but returned before law enforcement arrived;"
-8/23/22: prompted for cursing at peers, making inappropriate sexual comments, non-complaint with staff;
-8/29/22: drug tested for using Vape pen at school;
-8/30/22: bullying another client (Client #6) ...punched the office door while the Client #6 was inside ...walked out of facility without permission, came back after speaking with staff and left again;
-8/31/22: became physically aggressive when another client was being discharged; "He began kicking the walls and became physically and verbally aggressive ...left the facility without permission ...Law Enforcement found [Client #2] at another facility and was transported home;"
-9/1/22: "Staff received a call about [Client #2] threatening and yelling at staff at school;"
-9/3/22: antagonizing peers today, pushed a client to the ground during an outing and pulled multiple residents' pants down;
-9/4/22: " ...opened the bathroom door on purpose on another client, stuck stickers around the house with anti-gay slurs ...tried to stick his fingers up peers' anus' through shorts.. antagonizing a peer and when peer became aggressive back he rushed into the room pushing staff ...later this evening he rushed into the bathroom while client was in there and slapped him in the face;"
-9/13/22-"stormed into a staff office during a meeting...demanding to speak with facility supervisor," Vape pen found in his room;
-9/14/22: body slammed another resident, got picked up from school and walked out of facility,

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inappropriate gestures, language, and non-compliance.
-Vape pen found in his room;
-9/15/22: threatened to elope from school, used another peer's laptop to contact girlfriend, who showed up during a walk with facility staff;
-9/19/22: verbal aggression;
-9/20/22: verbal aggression ... "was upset at staff who would not allow him to call another facility staff who was off duty ....during another resident's crisis, he walked outside of the facility ...disrupted staff's conversation with peer and escalated the situation;"
-9/30/22: Client #8 was in crisis and attempted to stab Client #2 with a pencil ...Client #2 trapped Client #8's hands against the wall;
-10/8/22 and 10/9/22: antagonizing and bullying another client.

Review on 10/19/22 of Clinical Report Notes for Client #2 from 8/1/22 to 10/14/22 revealed:
-8/9/22 "got in to an altercation yesterday and physically harmed a peer ...peer has tried to come on to him ...plans on getting more tattoos"
-8/22/22 "..having peer issues and stated the next person that bothers him ...he is going to physically hurt them;"
-9/20/22 "discussed a peer that lives with him and some disturbing things that peer had done while at the [facility] ...has flashbacks to his past when his peer does sexual behaviors and makes him uncomfortable due to peer making moves on him a long time ago;"
-9/28/22 [facility] is ... testing his patience, there are 9 peers in the house right now and wants to get out As Soon As Possible (ASAP);
-10/4/22 angry with peers at the facility, feels like "physically harming them."

Review on 10/17/22 of Client #2's PCP dated

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V 112	Continued From page 26 6/21/22 and updated on 7/8/22, 8/4/22, and 9/8/22, revealed: "Long Term Goal: Get my anger under control and learn to express my feelings Short Term Goals: 1.Accept and follow the guidance of staff members in the facility setting by following the facility rules and utilizing staff as support; Goal Revised on 7/8/22: Work on emotion regulation skills due to past trauma As Evidenced By (AEB) using the STOPP technique; S-Stop T-Take a breath O-Observe thoughts and feelings; P-Pull-back; P-Practice what works and proceed; -being mindful and using healthy coping skills to deal with your emotions; 2. Will attend and complete assignments with passing grades during the academic day ...be respectful to staff and instructors and ask for assistance if needed; -complete daily journal, Bridge Assignments, hygiene, and chores. 3. Will increase his life skills and ability to function outside of a Residential group home by focusing on "staying in his lane" and not getting caught up in negative behaviors; Goal Revised on 7/8/22: Will display respect and kindness to others and tolerance towards peers AEB follow facility rules, communicate respectfully with staff and listen to re-direction, refrain from physical/verbal aggression." -there were no goals, interventions or strategies identified in the PCP to address the clients ongoing physical aggression, bullying of other clients, or elopements; -there was no documentation to support Client	V 112		

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V 112	Continued From page 27 #2's unsupervised time allowing 1:1 transportation by staff or walks with the PSS. Review on 10/17/22 of Client #3's record revealed: -Admission to Level II: 9/8/22; -Discharge and Re-Admission to Level III facility 9/12/22; -Age:15 -Diagnoses: PTSD, DMDD, and ADHD; Comprehensive Clinical Assessment (CCA) dated 7/13/21 noted history of threatening suicide, past delusional thinking/hallucinations, hospitalizations in 2020 for SI/HI, peer relational problems, IQ of 67, behavior that is consistent with Autism, difficulty managing emotions, aggression, school problems and an Individual Education Plan (IEP) -CCA addendum dated 8/17/22 recommended "a lateral level III placement and displayed significant intellectual disabilities that require a different level of care at this time." Review of Daily Notes from 8/1/22 to 10/9/22 for Client #3 revealed: -the first daily note for Level III facility is noted to be 9/12/22; -9/14/22: Vape pen found; -9/26/22: " ...became upset at another peer and walked out of facility ...reported a peer kept walking into his room making him uncomfortable;" -9/27/22: " ...staff discovered tattoo on left arm, he reported it had been there for nearly 5 days;" -9/30/22: he walked out of the facility after being called out for his behavior; -10/3/22: "...he and a peer left the facility this morning ... wondered around town;" -10/6/22: " ... refused to attend school or complete work." Review on 10/19/22 of the Clinical Notes for	V 112		

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V 112	Continued From page 28 Client #3 from 8/1/22 to 10/14/22 revealed: -9/8/22: "client does not know why he moved to [level II sister facility]..he liked it at [Level III facility]" -9/12/22: noted to be back at this (level III) facility; -9/20/22 Clinician "...reviewed client record and addendum to move to Level III care;" -9/21/22: "processed emotions around another client being inappropriate with sexual comments;" -9/27/22: "discussed leaving facility yesterday...peer making him uncomfortable...peer always talking sexually to everyone;" -9/29/22: client allowed another client to tattoo him; -10/1/22: documented need for more records and recent CCA: -10/3/22: walked out of facility this weekend with a peer when upset; -10/4/22: "... discussed with client reports from other clients that he is self-harming ...reports he is not self-harming, client doesn't want to take night meds because they are too strong...wants to go to level II." Review on 10/17/22 of Client #3's PCP dated 8/17/22 and updated on 9/22/22 revealed: "-Long Range Goal: To Get Out of Placements; -Short term Goals: 1. To accept and follow the guidance of staff members in the facility setting by following the facility rules and utilizing staff as support Goal Revised 9/22/22: will develop and utilize skills to reduce anger and manage moods swings by: -participate in therapy to learn emotion management skills, coping skills to learn during the day; -accept feedback from staff, including "no" without arguing -remain respectful to peers without participating in	V 112		

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behaviors that are intended to provoke peers
2. Will attend and complete his assignments with passing grades during the academic day, be respectful to staff and instructors and ask for assistance as needed.
-Client will complete his journal, Bridge assignments, hygiene and chores;
3. Will increase his life skills and ability to function outside of Residential Group Home by focusing on "staying in his lane" and not getting caught in negative behaviors.
Goal Revised 9/22/22: will work on emotion regulation skills due to past trauma AEB:
-Ability to recognize you are having an emotional response
-Using the STOPP Technique, and Emotional Acceptance: Being mindful and use healthy coping skills to deal with your emotions."
-there were no goals, strategies or interventions for Client #'s elopement, depression/self-harm, and school placement needs;
-there was no documentation to support Client #3's unsupervised time allowing 1:1 transportation by staff or walks with the PSS.

Review on 10/17/22 of Client's #1, #2, and #3's PCPs revealed that all three clients had the same strategies and interventions for every goal listed on their treatment plans as:
"HOW (Support/Intervention)
Client will:
-Participate in treatment without negativity
-Accept Criticism, Accept Accountability, Accept Disappointment
-"Stay in your Lane" during the Treatment Program
-Develop skills to identify when he is actively displaying a negative affect
-Practice utilizing coping skills with staff as needed

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V 112	Continued From page 30 -Accept feedback from authority figures to enhance skills to decrease negative affects -Adhere to behavioral agreements and contracts made by appropriate parties -Utilize opportunities to practice new cooperative skills and strategies around negative affects -Be compliant with a single staff during periods of transport to appointments, activities, or events -Participate with compliance and enthusiasm in daily exercise program Legal Guardian: -Actively participate in visits and safety planning -Demonstrate competency with supporting management of anger control by addressing negative affect incidents in all settings- visits, community outings -Support the treatment program and avoid negative discussion with the client regarding hurdles that may have presented themselves -Provide for the needs of the client (clothing, hygiene products, special snacks, and funding for activities while in treatment) Provider: -Provide safe treatment environment that includes- shelter, nutrition, hygiene, education, and physical activity -Utilize Love and Logic principles across program settings to reinforce skill development for success and managing anger and dysregulation -Maintain a structured program that encourages effort and pride in completion of successful benchmarks -When necessary, utilize the NCI+ (Non-Violent Crisis Interventions) Interventions to assist de-escalation and debrief after episodes of dysregulations -Case Manager/QP will assist in providing updates to guardians or MCOs (Managed Care Organizations) in monthly CFTs (Child and Family	V 112		

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Teams)
-AP (Associate Professional) will provide day to day guidance within the facility to direct care staff within policy of provider
Therapist:
-Support client, family, and staff by providing- individual sessions, weekly group skill building sessions, weekly staff trainings
Medication Management Provider:
-Provide medication management as needed to assist with regulation of negative affect.

Therapeutic Leave:
Therapeutic Leave is implemented as part of the Discharge/Transition Plan. The client and guardian will adhere to the following guidelines:
-Client will be on a home pass with his guardian
-Client will be with his guardian at all times
-Client will follow all rules by his guardian
-Client will not ingest any substances
-Client will report any issues concerning his mental health with his guardian and Clear Sky Behavioral Staff/ Clear Sky Behavioral (licensee) Clinical Team, will be notified immediately of these issues
-Client will take his medications as prescribed and no other medications, vitamins, supplements etc."

Interview on 10/11/22 with Client #1 revealed:
-had been at the facility 2 or 3 months; "came here, went to Level II and then came back here;"
-his goal was to "level down and get help with myself and live a more valuable future for myself;"
-saw the Therapist one time per week; sometimes at the facility or at her office;
-QP #2 did group therapy right before school, "it lasts about 30 minutes;"
-Client #5 was his roommate; he asked to move

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rooms 3 or 4 days ago because Client #5 "gets too angry and wants to fight ...gets aggressive ...masturbates at night, staff said they were trying to figure it out" (about room change).

Interview on 10/11/22 with Client #2 revealed;
-roommate is Client #3;
-"been living at [facility] for four months ...going to independent living ...not sure when;"
-liked living at the facility because it wasn't home;
-got driven to school in QP #2's car with Client # 8;
-when asked what goals he's working on at the facility, "to stop cussing;"
-when asked what do you do after school, "sleep;"
-"a week ago, my roommate gave another peer his meds ..... me and several peers have tattooed ourselves."

Interview on 10/11/22 and 10/24/22 with Client #3 revealed:
-his current roommate was Client #2..had moved around to other rooms before;
-he had "no clue" how long he'd been at the facility ... "but no more than 3 months;"
-he ran away when he got upset ...but he always came back;
-cheeked meds "a couple weeks ago and gave it to [Client #7] ...and told staff ...now they watch me;"
-showed surveyors his tattoo on his left arm ... "it took a couple days and nights to do it;"
-confirmed two of his housemates got into a fist fight about food;
-regarding his bed being pushed together with Client #2's bed in their room, "staff let us..they didn't really say anything about it;"
-had observed a kid from another facility sleeping in the living room here ... "that was one time, a couple weeks ago ...I don't know why;"

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-his goals were "...not cussing, not running away;"
-during the day, he went to school online at the facility or at "[NC WORKS]."

Observation at 4:09pm on 10/11/22 of Client #3 revealed:
-a tatoo on his upper left arm.

Interview on 10/13/22 with Client #2's guardian revealed:
-her son has extreme mental health issues and they've exhausted community and school resources;
-only concern was "when facility staff would report that he was doing well ...being respectful, and then at meetings would say, they weren't sure they could keep him due to his behaviors ...he may be more than what the facility could offer;"
-"staff was saying one thing ...leadership another..and clarified at the last Child and Family Team (CFT);"
-her son "was a bullying kind of person ...intolerant of noises ...disrespectful of people ...can threaten people ...believed he put in in his fair share of the problem."

Interviews on 10/11/22, 10/14 and 10/24/22 with the Operations Director/Behavioral Health Facilitator (OD/BHF) revealed:
-Client #1 was going to a PRTF;
-"when [Client #2] came to the facility ...he beat everyone's brain ... he's not made it to Level II yet..he's trying;"
-Client #2 has done a lot better since a medication change 9/22/22 ... "he still barks off but not like he used to;"
-she uses a "calm voice and removes the audience" to deal with Client #2's aggression;
-the facility was supposed to have a training coming up to share strategies about aggression;

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V 112	Continued From page 34 -"[Client #3] is definitely low IQ..littlest things will make him blow up." Interview on 10/24/22 with the AP revealed: -Client #1 was going to a PRTF; -Client #2 had made a lot of progress in the past few weeks ... "have had some pretty stern talks with him ...he has impulse and maturity issues." Interview on 10/13/22 with the BHD/QP#1 revealed: -Client #2 was an impulsive kid.. "don't have a bed for him at Level II;" -they made sure Client #3 and Client #4 "don't have anything sharp ...our clinician has been talking to him about tattooing and drawing on himself"; -he did not know why Client #3 and Client #2's beds were pushed together in their room, but he would address it. Interview on 10/12/22 with the Administrator revealed: -due to a survey in 2018, they have added a statement in the PCPs about " being compliant with a single staff during periods of transport to appointments, activities, or events." -he is going to address the PCPs at an informal conference with Division of Health Service Regulation; -he would address the beds being pushed together; -"trending behaviors are now going to be put in PCPs;" -"[local county school system] is going to have to meet them in the middle ....and give clients some paperwork to do in meantime ...even it its just practice." This deficiency is cross referenced into 10A	V 112	This concern was relative to the goals of the PCP not matching the recent incidents or emergency CFT concerns. We were writing longer narratives at the conclusion of the CFT but leaving relative goals in place. Clear Sky Behavioral understands the immediate concern of revising the goals and has amended policy to reflect any trending type incidents and emergency CFT concerns. This process has been put in place company wide. All case management and QPs have been trained of this requirement to change goals and highlight any client specific interventions relative to the client being served. This concern was discussed during the informal appeal process and currently awaiting the findings of this.	12/1/2022

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V 112	Continued From page 35 NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 112	This concern was previously presented in an informal appeal in October 2018. The concern was based upon a ratio of 3:8 staff/ client. The discussion was pointed out that during periods of travel we had concerns as to ratio being possible. Examples as follows: • 1 child becomes ill and needs transported to the doctor. This leaves 7 in the house with 2 staff members will leave both scenarios out of ratio. • 7 children are transported to an activity and 1 remains in the home sick. 7 children at the off campus activity will be out of ratio with 2 staff members and the 1 left in the home will be out of ratio with a single staff member. Of the (8) children in the facility, they attend 3 different schools each day. The transportation has been performed by a single staff member as to ensure 2 remain in the facility. During the period of this citation, the van was transporting (7) residents to the facility from volunteering at the food hub and then another group was attending career readiness training at NC Works. Due to this citation, we have suspended all volunteer efforts and career readiness training as to staffing concerns with ratio. During the informal of 2018, it was agreed upon that a statement would be placed on the PCP regarding transportation by a single staff member. This has been the practice since 2018 and still in place to this day. There was also a concern relative to our clinical peer support staff member taking single clients out of the facility to go for walks as they attend sessions. This is an Out Patient Therapy service that is NOT billed in connection with the residential Level III service. We have suspended these sessions due to the survey concern but would like this reinstated upon review of the corrective action plan.	12/1/2022
V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to a community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint;	V 293		

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V 293	Continued From page 36 (4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care. This Rule is not met as evidenced by: Based on record review, interviews, and observations, the facility failed to provide the level of supervision and structure to provide intensive, active therapeutic treatment and interventions within a system of care approach affecting 3 of 3 audited clients (Client #1, Client #2, and Client #3). The findings are: Cross Reference: 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109). Based on record review and interviews, 1 of 2 Qualified Professionals, (Behavioral Health Director/Qualified Professional #1 (BHD/QP#1)) failed to demonstrate the knowledge, skills, and abilities required by the population served. Cross Reference: 10A NCAC 27G .0204 Competencies and Supervision of	V 293	My corrective action would be to add this intervention to the PCP as "Client are encouraged to practice safety and compliance during periods of off campus clinical services."	

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V 293	Continued From page 37	V 293		

Paraprofessionals (V110). Based on record reviews and interviews, 1 of 4 audited Paraprofessionals (Operations Director/ Behavioral Health facilitator (OD/BHF)) failed to demonstrate the knowledge, skills and abilities required by the population served.

Cross Reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V111). Based on record reviews and interviews, the facility failed to have an assessment that accurately reflected the presenting problems and needs of the clients affecting 2 of 3 audited clients (Client #1 and Client #3).

Cross Reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112).
Based on record reviews and interviews, the facility failed to develop and implement goals and strategies to address the treatment needs of 3 of 3 audited clients (Client #1, Client #2, Client #3).

Cross Reference: 10A NCAC 27G .1704 Minimum Staffing requirements (V296). Based on observations, record reviews and interviews, the facility failed to meet minimum staffing affecting 3 of 3 audited clients (Client #1, Client #2 and Client #3).

Cross Reference: 10A NCAC 27G .1706 Operations (V298). Based on observation, record review, and interviews, the facility failed to coordinate educational services for 1 of 3 audited clients (Client #1).

Cross Reference: 10A NCAC 27G Incident Response Requirements for Category A and B Providers (V367). Based on record review and

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V 293	Continued From page 38 interviews, the facility failed to submit Level 2 incidents within 72 hours to the local management entity/managed care organization (LME/MCO) as required. Cross Reference: 10A NCAC 27E .0101 Least Restrictive Alternative (V513). Based on observations and interviews, the facility failed to use the least restrictive and most appropriate settings and methods affecting 3 of 3 audited clients (Client #1, Client #2 and Client #3). Cross Reference: 10A NCAC 27E .0107 Training on Alternative to Restrictive Interventions (V536). Based on record reviews and interviews, the facility failed to ensure that 1 of 6 audited staff (Direct Support Professional #2 (DSP #2)) had completed training annual refresher training in alternatives to restrictive interventions prior to providing services. Cross Reference: 10A NCAC 27E .0108 Training in Seclusion, Restraint, and Isolation Time-out (V537). Based on record reviews and interviews, the facility failed to ensure that 3 of 6 audited staff (DSP #2, #3 and the Behavioral Health Specialist/Peer Support Specialist (BHS/PSS)) had training in seclusion, physical restraint, and isolation time-out prior to providing services. Cross Reference: 10A NCAC 27G .0303 Location and Exterior Requirements (V736). Based on observation and interview, the facility failed to be maintained in a safe, clean, attractive, and orderly manner. Review on 10/21/22 of the initial Plan of Protection (POP) written by the Administrator dated 10/21/22 revealed: " What immediate action will the facility take to	V 293	Clear Sky Behavioral, for many years, practiced a “block and move” policy and didn’t authorize any restrictive type interventions. We recently implemented in policy that staff could be trained in restrictive interventions to help alleviate the overuse of police involvement for certain circumstances. Within the Clear Sky Behavioral policy it stated that 3 circumstances allowed the use of restrictive interventions for employees trained to provide this extra measure of safety within the facility. 1) Self Harm, (2) Physical Confrontation or Assaultive Behaviors, (3) Elopement, when the age of the child or cognitive ability of the child presents a danger to them. We train all employees in NCI Prevention and Defensive Interventions but purposely did not train every employee in the ability to utilize restrictive interventions. This is a measure that we only felt comfortable utilizing with seasoned and capable staff. We felt our female staff could become injured or some staff may go to far with the restrictive intervention. We felt it would be our choice as to who we would authorize to utilize restrictive interventions. Nonetheless, after this survey, we have trained 100% of our staff in the use of restrictive interventions. At this point all Level III staff will be trained in NCI Prevention, Defensive, and Restrictive measures.	12/1/2022

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V 293	Continued From page 39 ensure the safety of the consumers in your care? Please review the attached addendum for details of each area of concern. Describe your plans to make sure the above happens. Many of the items listed were identified in a survey of other facilities and were company wide concerns. The others identified in this Plan of Protection will be implemented at the earliest possibly date via staff training, direct changes to daily protocol, or revisions to company policy. These actions have already been passed along to the Level III team and the process for compliance has begun. Minimum Staffing Requirements This concern was originally discovered due to our population being at multiple events throughout the day. We had clients at Career Readiness Training, Tutoring, Adult High School Program, and the Food Hub Volunteer Program. Many of these are taking place at the same times throughout the day and do not encompass all clients at one location. We have since terminated our involvement in any unnecessary programs that are not relative to the academic day. The ratio concerns have been relative to transportation to multiple places and the arrival back to the facility at various times. By terminating the additional community-based activities this has been corrected. We also had a peer support person completing (1) hour of service per week with the Level III population. She was taking them off campus to complete this duty. It was assumed by Clear Sky Behavioral (licensee) management that she would not count as direct care ratio during the clinical based duties. We are mandating that all of her duties for	V 293	This facility is a Level III facility and takes a lot of abuse from the clients served. We have a full time repair man that repairs holes in the walls and doors that have been broken from the hinges. These are common response when this population is faced with "NO" as a staff response to something they want. Based on this audit and a further audit conducted by DHSR Construction section, we have replaced all flooring in the home with vinyl plank style flooring. This is a very durable option and will last for many years. The HVAC has also been upgraded to mini-split units in each of the living areas. The suspended ceiling tiles have been replaced or repaired to ensure no air gaps exists in the roof membrane. All doors properly close and all walls have been patched. This critical area will need more time than 23 days to complete as DHSR construction had given a timeline of 45 days from the date of deficiencies are received. However, the cosmetic areas noted by the DHSR Surveyors has already been corrected.	12/1/2022

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V 293	Continued From page 40 level III residents be performed on campus. This concern is currently in compliance. Operations This concern was based on the locked kitchen and food access of residents throughout the day. It truly is imperative that the kitchen is locked in a Level III facility due to the likelihood of sharp items being taken from this area. The corrective measures we will take to alleviate this concern is to have a fruit basket, made up of apples and oranges, outside of the kitchen. The residents would be able to access this without snack involvement and offer them a healthy choice snack throughout the day. Our nutrition policy, which includes scheduled meal and snack times, has been previously approved on a separate survey from another facility. This policy offers a standard stock of food items that are replenished every Friday. The entire 31 day menu has been discussed in detail with our resident representatives and all approved of the changes made via the Human Rights Committee. This concern will be corrected by 10/21/2022. Nutrition Policy is attached Assessment and Treatment -Services Plan The PCP (Person Centered Plan) policy was revised based on the survey of a previous location to include revision of goals based on Emergency CFT (Child and Family Team) reporting and also Trending Incidents. Our previous practice was to update the narrative with emergency CFT data prior to issuance of a Notice of Discharge. The implementation of goal revision is already in progress and all staff have signed and acknowledged this revision in a staff training memorandum. PCP Policy is Attached Competencies and Supervisions of	V 293	Clear Sky Behavioral keeps the kitchen locked at all times in facilities that allow the area to be secured. This is an effort to remove clients from areas of sharp objects in a mental health treatment program. Due to the concern of healthy snacks, we are currently leaving a fruit basket out in accessible areas for clients to have healthy snacks at all times of the day. This was a compromise to leaving the kitchen open and the risk of danger that presents itself in a facility. This action was implemented immediately. This concern was relative to the goals of the PCP not matching the recent incidents or emergency CFT concerns. We were writing longer narratives at the conclusion of the CFT but leaving relative goals in place. Clear Sky Behavioral understands the immediate concern of revising the goals and has amended policy to reflect any trending type incidents and emergency CFT concerns. This process has been put in place company wide. All case management and QPs have been trained of this requirement to change goals and highlight any client specific interventions relative to the client being served. This concern was discussed during the informal appeal process and currently awaiting the findings of this.	11/15/2022 12/1/2022

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V 293	Continued From page 41 Paraprofessionals This citation was relative to a order being provided by our Clinician to maintain strict "eyes on" supervision of a client due to concerns she had with his ability to be safe. This was interpreted as following the client to and from the restroom and maintaining constant watch over his movements. This client was in the facility for 30 days waiting on a PRTF (Psychiatric Residential Treatment Facility) bed. Clear Sky Behavioral has recently moved its Behavioral Health Director to on-site at the Level 3 building in efforts to increase the ratio of staff and to streamline communication from the clinical to the residential team. This is currently in effect for future communications and the client of concern was discharged on 10/20/2022. Competencies of Qualified Professionals and Associate Professionals Initial Assessment Screening Tool has been revised to include licensed clinician input into review of documentation. The Behavioral Health Director will complete the screening tool for basic disqualifiers and upon approval, the assessment tool will be passed on to the clinician for clinical document review. The documents provided by the guardian must encompass a minimum of the past 6 months. This would include the most current annual CCA (Comprehensive Clinical Assessment) and CCA Addendum recommending the level of care, the most current PCP. If any document is newer than 6 months, the previous document must be included in the review. Once the clinician has had an opportunity to review clinical documentation, she will utilize her best judgment as to Clear Sky Behavioral ability to serve this client. If approved at the clinical level, a face-to-face meeting will be scheduled with the Behavioral Health Director for	V 293	This concern is relative to the initial assessment plan that Clear Sky Behavioral, LLC has been using following a survey in 2018. This form and process was approved during this audit but has been modified to meet concerns of this survey team. The question was posed that, “why does our staff clinician not participate in the intake process.” The Clear Sky Behavioral response to this question is that Level 2 facilities typically doesn’t have a staff clinician to utilize. It is relied upon for the QP to make these decisions. The clinical documents many times are tailored to fit the vacant bed from the guardian or previous residential provider. We are getting documentation that reflects the appropriate level of care . Sometimes these children are recently taken into custody and MCOs suggest least restrictive option as the starting point for services. We also have children stepping down after stays in PRTF settings and the MCOs are reducing funding for a trial period. Many times, we get these cases and turn around a level them right back up. These are genuine concerns in this industry. We utilize an “Immediate Liability Form” in an attempt to create automatic declines for Gang activity, Sexualized behaviors, and assaultive behaviors. The initial assessment screening tool form is used to discuss the case with the guardian as an initial step prior to receiving the clinical documents that are shared. This form will sometimes differ from the clinical documents because it is based upon the details provided by the child family team. This process has been revised with slight changes to the form as suggested by the DHSR survey team and also to incorporate a clinical review of documents that utilize a minimum of 6 months lookback. We have also reluctantly added a review by our staff clinician for another layer of approval. This has been discussed during the informal appeal process and awaiting the results of this area of concern.	12/1/2022

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V 293	Continued From page 42 final approval. If at any level of the process, the client is declined, the process will stop and the guardian will be notified of non-acceptance to the Clear Sky Behavioral program. The areas that will continue will be screening out of Gang Related Activity, Sexualized Behaviors, Assaultive or Aggressive Behaviors, and will now include past elopement concerns. Clinical Documentation standards will include the most recent annual Comprehensive Clinical Assessment (CCA) and Addendum and also the Person-Centered Plan (PCP). If any documentation is less than 6 months old, the previous CCA and PCP will be requested. The assessment policy has also been revised to include details regarding detailed steps taken from the receipt of the initial referral, clinical document review, and meet and greet that includes program expectations with the potential client. This period of the review will be 3-7 days from receipt of the referral to final approval. Admissions and Assessment Policy are attached. Client Services This concern was relative to a child that arrived not starting school until 10/20/2022. This child was enrolled in school upon arrival and took the placement test to start. [Local] county doesn't offer an alternative school setting and it has become our academic resource to partner with NC Works Adult High School program to facilitate the academics of our 16 and 17 year olds. This academic platform runs on 9 week semesters with minimal classes. The school gives us a start date for the child once the enrollment process is complete. In this case the client start date was 10/20/2022. The advantage to the 9 week timeline is that each student will get 2.5 times the semester completion as a single semester in public type school. All of our guardians are aware	V 293	This concern presented itself due to one resident starting school on October 20, 2022. He arrived during the month of July and this was considered summer break until the first week of September. This resident had already tested into the program and was slated to start school at the beginning of the following semester. This program has shorter, more intense, schedule of 9 weeks per semester. This in comparison to the public school semester lasting 4 months. It was discussed with the survey team that his waiting until the following semester beginning would not put his academics behind in any way. They complete double the amount of work in a 4 month period as public school. His start date is decided by the Adult High School program and we have little to do with this schedule. Due to this survey, we have met with the school administration and they have agreed to offer online based credits for children that are stuck between start dates. This will be on a case by case scenario with birthdate, academic status, and Child Family team decisions weighing heavily on the decision being made. Currently, all children are served academically with none left in limbo. The new semester will begin in January 2023 with the online option being available to students.	12/1/2022

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V 293	Continued From page 43 of this and our clients understand that sometimes you wait to start but when you do everything moves very quickly. Most of our clients graduate high school before they turn 18. I will provide a letter of explanation from the dean of the program and the enrollment paperwork for this client as quickly as it is received. Incident Response Requirements (IRIS) This duty was reassigned mid-September to be completed by a staff AP (Associate Professional) and no longer completed by our Behavioral Health Director as part of his duties. This audit spanned a timeframe of (3) months. This is likely that the delinquent IRIS reports took place during a period of time farther back that mid- September 2022. Clear Sky Behavioral will remediate the policy for IRIS submission and also the Matrix scale to ensure Incident reports are submitted timely and accurately. This will be completed by close of business on 10/21/2022. Staff training report will be completed with signatures of all QP's and APs directly responsible for this duty. Least Restrictive Alternatives, Restrictive Concerns In the past employees have been trained in NCI prevention and defensive parts only with a few being trained in restrictive interventions. This was a cautious decision of management to prevent overuse of restrictive techniques by newly hired staff members. During orientation employees are trained on the intervention policy. Due to this survey, we will train all Level III staff in the use of approved restrictive interventions that include the therapeutic wrap and bear hug techniques. This will be completed by 10/28/2022. All employees will be trained in these techniques prior to commencement of any direct care position.	V 293	Clear Sky Behavioral, for many years, practiced a “block and move” policy and didn’t authorize any restrictive type interventions. We recently implemented in policy that staff could be trained in restrictive interventions to help alleviate the overuse of police involvement for certain circumstances. Within the Clear Sky Behavioral policy it stated that 3 circumstances allowed the use of restrictive interventions for employees trained to provide this extra measure of safety within the facility. 1) Self Harm, (2) Physical Confrontation or Assaultive Behaviors, (3) Elopement, when the age of the child or cognitive ability of the child presents a danger to them. We train all employees in NCI Prevention and Defensive Interventions but purposely did not train every employee in the ability to utilize restrictive interventions. This is a measure that we only felt comfortable utilizing with seasoned and capable staff. We felt our female staff could become injured or some staff may go to far with the restrictive intervention. We felt it would be our choice as to who we would authorize to utilize restrictive interventions. Nonetheless, after this survey, we have trained 100% of our staff in the use of restrictive interventions. At this point all Level III staff will be trained in NCI Prevention, Defensive, and Restrictive measures.	12/1/2022

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V 293	Continued From page 44 Location and Exterior Requirements These items have been noted upon construction inspection. The majority of these things are relative to the carpet being dirty and various suspended ceiling tiles being moved and broken. We have a full-time repair man that repairs holes in walls, doors being broken, and these things are very regular. The replacement of flooring has been on our strategic plan but having access to complete the work without disruption of the client schedules has been difficult to plan. Since this survey and construction inspection, we have went ahead with the repairs as required. We are in the process of replacing the floor covering with vinyl plank flooring and other items noted on the construction review. This will be fully completed by November 1, 2022. See picture shown below:" (Picture was attached to POP). Review on 10/21/22 of the amended POP written by the Administrator and dated 10/21/22 revealed: " What immediate action will the facility take to ensure the safety of the consumers in your care? Please review the attached addendum for details of each area of concern. Describe your plans to make sure the above happens. Many of the items listed were identified in a survey of other facilities and were company wide concerns. The others identified in this Plan of Protection will be implemented at the earliest possible date but not later than 10/28/2022. This will be completed via staff training, direct changes to daily protocol, or revisions to company policy. The facility construction projects for compliance have already began and will be completed no later than 11/30/2022.	V 293	This facility is a Level III facility and takes a lot of abuse from the clients served. We have a full time repair man that repairs holes in the walls and doors that have been broken from the hinges. These are common response when this population is faced with “NO” as a staff response to something they want. Based on this audit and a further audit conducted by DHSR Construction section, we have replaced all flooring in the home with vinyl plank style flooring. This is a very durable option and will last for many years. The HVAC has also been upgraded to mini-split units in each of the living areas. The suspended ceiling tiles have been replaced or repaired to ensure no air gaps exists in the roof membrane. All doors properly close and all walls have been patched. This critical area will need more time than 23 days to complete as DHSR construction had given a timeline of 45 days from the date of deficiencies are received. However, the cosmetic areas noted by the DHSR Surveyors has already been corrected.	12/1/2022

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V 293	Continued From page 45 Addendum: Minimum Staffing Requirements This concern was originally discovered due to our population being at multiple events throughout the day. We had clients at Career Readiness Training, Tutoring, Adult High School Program, and the Food Hub Volunteer Program. Many of these are taking place at the same times throughout the day and do not encompass all clients at one location. We have since terminated our involvement in any unnecessary programs that are not relative to the academic day. The ratio concerns have been relative to transportation to multiple places and the arrival back to the facility at various times. By terminating the additional community-based activities this has been corrected. We also had a peer support person completing (1) hour of service per week with the Level III population. She was taking them off campus to complete this duty. It was assumed by Clear Sky Behavioral management that she would not count as direct care ratio during the clinical based duties. We are mandating that all of her duties for level III residents be performed on campus. This concern is currently in compliance. Operations This concern was relative to a child that arrived not starting school until 10/20/2022. This child was enrolled in school upon arrival and took the placement test to start. [Local] county doesn't offer an alternative school setting and it has become our academic resource to partner with NC Works Adult High School program to facilitate the academics of our 16 and 17 year olds. This academic platform runs on 9 week semesters with minimal classes. The school gives us a start date for the child once the enrollment process is complete. In this case the client start date was	V 293		

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V 293	Continued From page 46 10/20/2022. The advantage to the 9 week timeline is that each student will get 2.5 times the semester completion as a single semester in public type school. All of our guardians are aware of this and our clients understand that sometimes you wait to start but when you do everything moves very quickly. Most of our clients graduate high school before they turn 18. I will provide a letter of explanation from the dean of the program and the enrollment paperwork for this client as quickly as it is received. Clear Sky Behavioral will reach out to NC Works and coordinate a potential of academic packets that future students could complete while they are awaiting a class seat. This will need to be followed up as it will take a coordinated effort between community partners. We would want to ensure some credit is given to the student for this added effort. Least Restrictive Alternatives This concern was based on the locked kitchen and food access of residents throughout the day. It truly is imperative that the kitchen is locked in a Level III facility due to the likelihood of sharp items being taken from this area. The corrective measures we will take to alleviate this concern is to have a fruit basket, made up of apples and oranges, outside of the kitchen. The residents would be able to access this without snack involvement and offer them a healthy choice snack throughout the day. Assessment and Treatment -Services Plan Initial Assessment Screening Tool has been revised to include licensed clinician input into review of documentation. The Behavioral Health Director will complete the screening tool for basic disqualifiers and upon approval, the assessment tool will be passed on to the clinician for clinical document review. The documents provided by the guardian must encompass a minimum of the	V 293		

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V 293	Continued From page 47 past 6 months. This would include the most current annual CCA and CCA Addendum recommending the level of care, the most current PCP. If any document is newer than 6 months, the previous document must be included in the review. Once the clinician has had an opportunity to review clinical documentation, she will utilize her best judgment as to Clear Sky Behavioral ability to serve this client. If approved at the clinical level, a face-to-face meeting will be scheduled with the Behavioral Health Director for final approval. If at any level of the process, the client is declined, the process will stop and the guardian will be notified of non-acceptance to the Clear Sky Behavioral program. The areas that will continue will be screening out of Gang Related Activity, Sexualized Behaviors, Assaultive or Aggressive Behaviors, and will now include past elopement concerns. Clinical Documentation standards will include the most recent annual Comprehensive Clinical Assessment (CCA) and Addendum and also the Person-Centered Plan (PCP). If any documentation is less than 6 months old, the previous CCA and PCP will be requested. The assessment policy has also been revised to include details regarding detailed steps taken from the receipt of the initial referral, clinical document review, and meet and greet that includes program expectations with the potential client. This period of the review will be 3-7 days from receipt of the referral to final approval. The PCP policy was revised based on the survey of a previous location to include revision of goals based on Emergency CFT reporting and also Trending Incidents. Our previous practice was to update the narrative with emergency CFT data prior to issuance of a Notice of Discharge. The implementation of goal revision is already in progress and all staff have signed and	V 293		

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acknowledged this revision in a staff training memorandum. Assessment Policy, Admission Policy, and PCP Policy is Attached.
Competencies and Supervisions of Paraprofessionals
This citation was relative to an order being provided by our Clinician to maintain strict "eyes on" supervision of a client due to concerns she had with his ability to be safe. This was interpreted as following the client to and from the restroom and maintaining constant watch over his movements. This client was in the facility for 30 days waiting on a PRTF bed. Clear Sky Behavioral has recently moved its Behavioral Health Director to on-site at the Level 3 building in efforts to increase the ratio of staff and to streamline communication from the clinical to the residential team. [Operations Director/Behavioral Health Facilitator] is our direct care team lead and will have daily briefs with the Behavioral Health Director to coordinate protocols, policy, and concerns. This is currently in effect for future communications and the client of concern was discharged on 10/20/2022.
Competencies of Qualified Professionals and Associate Professionals
The Behavioral Health Director will be the initial intake point for referrals. He will review the initial assessment screening tool with the guardian to eliminate obvious disqualifiers for admission to Clear Sky Behavioral programs. If the potential resident is deemed to be a potential candidate, the clinical documentation along with the initial screening tool will be passed on to the Clinical Director. This process could take several days. If the Clinical Director accepts the candidate, it will go back to the Behavioral Health Director for Face-to-Face or Virtual Type Meet and Greet. This will prove to be the final step in the admission process. If at any point during the

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process, a reviewer denies admission, the process stops there. This is currently being utilized for future referrals.
Client Services
Our nutrition policy, which includes scheduled meal and snack times, has been previously approved on a separate survey from another facility. This policy offers a standard stock of food items that are replenished every Friday. The entire 31 day menu has been discussed in detail with our resident representatives and all approved of the changes made via the Human Rights Committee. This concern will be corrected by 10/21/2022. Nutrition Policy is attached
Incident Response Requirements (IRIS)
This duty was reassigned mid-September to be completed by a staff AP and no longer completed by our Behavioral Health Director as part of his duties. This audit spanned a timeframe of (3) months. This is likely that the delinquent IRIS reports took place during a period of time farther back that mid- September 2022. Clear Sky Behavioral will remediate the policy for IRIS submission and also the Matrix scale to ensure Incident reports are submitted timely and accurately. This will be completed by close of business on 10/21/2022. Staff training report will be completed with signatures of all QPs and APs directly responsible for this duty.
Least Restrictive Alternatives, Restrictive Concerns
In the past employees have been trained in NCI prevention and defensive parts only with a few being trained in restrictive interventions. This was a cautious decision of management to prevent overuse of restrictive techniques by newly hired staff members. During orientation employees are trained on the intervention policy. Due to this survey, we will train all Level III staff in the use of approved restrictive interventions that include the

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V 293	Continued From page 50 therapeutic wrap and bear hug techniques. This will be completed by 10/28/2022. All employees will be trained in these techniques prior to commencement of any direct care position. Location and Exterior Requirements These items have been noted upon construction inspection. The majority of these things are relative to the carpet being dirty and various suspended ceiling tiles being moved and broken. We have a full-time repair man that repairs holes in walls, doors being broken, and these things are very regular. The replacement of flooring has been on our strategic plan but having access to complete the work without disruption of the client schedules has been difficult to plan. Since this survey and construction inspection, we have went ahead with the repairs as required. We are in the process of replacing the floor covering with vinyl plank flooring and other items noted on the construction review. This will be fully completed by November 1, 2022. See picture shown below: (Picture attached to POP)." This level facility serves eight adolescent males with diagnoses including Disruptive Mood Dysregulation Disorder (D/O), Unspecified Trauma and Stressor Related D/O, Borderline Intellectual Functioning, Conduct Disorder, Encounter for Mental Health Services for Perpetrator of Non-Parental Sexual Abuse, Post Traumatic Stress D/O, Attention Deficit Hyperactivity Disorder (ADHD), and Static Encephalopathy. Admission assessments for two of the three sampled clients did not reflect the treatment needs of the clients or level of care needed. Treatment Plans for the three sampled clients did not have goals, strategies, or interventions of how to deal with identified behaviors of elopement, bullying, self-harm, physical aggression, and sexualized behaviors.	V 293		

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V 293	Continued From page 51 Client #1 and Client #3 were moved to a lower level of care sister facility, internally, due to short-term behavioral compliance and Local Management Entity (LME) authorization respectively. Both clients were re-admitted to the level III facility. Client #1 was re-admitted to the Level III on 9/21/22 and the guardian had already been issued a discharge notice. Client #3 was not re-assessed when he was re-admitted. The BHD/QP#1 failed to report level II incidents as required. Client #1 had sexualized behaviors with other clients in this facility and a sister facility. Staff did not follow therapist recommendation for supervision of Client #1 to be "eyes on" until he was discharged, despite the documented need and his risk to offend other kids. Client #1 was admitted to the facility on 7/14/22, re-admitted on 9/21/22, discharged on 10/20/22, and started attending school on 10/17/22. Client #2 had 7 physical aggression incidents and 3 elopements noted from 8/1/22 to 10/14/22 and bullied the other clients in the home. The facility was observed to have heavily stained and torn carpet throughout, a stained concrete shower floor , damaged and ripped ceiling tiles, a busted bedroom door, and chunks of wall paneling missing. Clients are adolescent males, and the kitchen was always locked, limiting access to food. Clients had 30 minutes of individual therapy once a week and got to leave the facility or school and walk with a peer support specialist for an hour despite being leveled for Level III care. It was noted that there were additional incidents of physical aggression with sampled clients that came out through interview that were not documented or reported. The facility does not train all staff on current NCI + restrictive interventions, although in its own policy and treatment plans for all three sampled clients, approved two restrictive interventions.	V 293		

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V 293	Continued From page 52 This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $_2,000.00_ has been imposed. If the violation is not corrected within 23 days, an additional penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 293		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and	V 296		

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V 296	Continued From page 53 (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to meet minimum staffing requirements of 2 direct care staff for one, two, three, or four adolescents and 3 direct care staff for five, six, seven or eight adolescents in the home or community affecting 3 of 3 audited clients (Client's #1, #2, and #3). The findings are: Refer to V111 for clients' admission dates and diagnoses. Refer to V112 for Person Centered Plan goals. Observation on 10/07/22 at 11:53AM of the facility revealed: -there were 7 clients present (Client's #'1, #2, #3, #4, #5, #6, and #8) with 1 staff, Direct Support	V 296		

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Professional #3 (DSP #3);
-Client #7 was reported to be at school;
-clients were running in and out of the facility and arguing;
-at 12:06PM, Behavioral Health Director/Qualified Professional #1 (BHD/QP #1) pulled into the facility parking lot and left;
-2 clients left with the Peer Support Specialist on foot (walk).

Interview on 10/7/22 with DSP #1 revealed:
-DSP #3 "was supposed to be taking the kids to [local state park] today and call when he was on his way back, but he didn't."

Interview on 10/7/22 and 10/11/22 with the Operations Director/Behavioral Health Faciliator (OD/BHF) revealed:
-the facility was out of ratio on 10/7/22 because one staff "didn't make a phone call;"
-she and another staff took clients to school in the morning, not the overnight staff;
-QP #2 drove some clients to school in his personal car; sometimes another staff will "hop in"
-QP #2 randomly picked the clients he was going to transport.

Interview on 10/11/22 with Client #1 revealed:
-"one staff takes us places;"
-last weekend (weekend of 10/8/22) there was only one staff; one staff didn't come in.

Interview on 10/11/22 with Client #2 revealed:
-there were 2 staff here on the weekend and 2 staff at night.

Interview on 10/11/22 with Client #3 revealed:
-for outings there are 2 staff but last weekend, "[DSP #3] worked by himself for some reason"

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-"if there are 2 staff here, 1 staff goes to the park"
-"for those who have privileges, they go to the park and those that don't stay here...can't remember if there is 2 or 1 staff so I guess if only 2 staff here, 1 goes and 1 stays."

Interview on 10/14/22 with Client #4 revealed:
-there were "mostly two staff ...when we go somewhere ... 1 staff to 3 kids .....if all the kids."

Interview on 10/12/22 with the Administrator revealed:
-during the 2018 DHSR (Divsion of Health Service Regulation) survey, he was informed that if a client is transported by 1 staff, it had to be on the PCP, "that is why we put in the PCPs that kids will be compliant with 1 staff person with transportation;"
-if he was out of ratio, "I own that"
-he quit going to the "food hub, NC works, and volunteering" due to needing additional staff to meet ratio while transporting clients;
-when DHSR co-surveyors were present that Friday (10/7/22), he "didn't have an excuse" for being out of ratio;
-the facility was "overstaffed," they used staff from the Level III facility to fill in at other facitlies; there were 5 staff there (Level III facility) during the week.

Interview on 10/17/22 with the DSP #3 revealed:
-his position was Direct Support Professional;
-he typically worked 7:00am-7:00pm;
-his supervisor was the OD/BHF;
-to transport clients, if they have eight clients and 3 staff, "sometimes we split up" some will take clients in the van with 2 staff and 3 will go in a car "1 staff and 2 clients"
-"sometimes if we plan an activity, if only 1 or 2 kids have privileges, they go with 1 staff and the

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V 296	Continued From page 56 rest of us go in the van." Interview on 10/24/22 with the Behavioral Health Specialist/Peer Support Specialist (BHS/PSS) revealed: -had worked for the Licensee since May 2022; -she walked and talked with the clients about their week ..."go around Main Street, shoot basketball ...when they are at school, go and do disc golf;" -she had hour long sessions with each client; -if she had concerns; she would talk to the OD/BHF or QP #2. Interview on 10/24/22 with QP #2 revealed: -he drove the adult high school clients to school; "typically it's 2 or 3 kids;" -"the other staff took the middle school kids;" -he brought this up with the Administrator because they were not meeting staff ratio; -"it's in the PCP (Person Centered Plan) ...one staff member can drive the adult high school kids and one staff can drive the other kids." Review on 10/18/22 and 10/19/22 of Outpatient Plus Therapy notes for Client #1, Client #2, and Client #3 revealed: -Client #1 and the BHS/PSS went for one-hour walks on 8/1/22, 8/8/22, 8/15/22, 8/22/22, 9/15/22, 9/20/22, 9/27/22, 10/3/22, 10/6/22, 10/10/22; -Client #2 and the BHS/PSS went for one-hour walks on 8/1/22, 8/9/22, 8/16/22, 8/22/22, 8/30/22, 9/6/22, 9/12/22, 9/20/22, 9/28/22, 10/4/22, 10/13/22; -Client #3 and the BHS/PSS went for one-hour walks on 9/14/22, 9/20/22, 9/27/22, 10/7/22, 10/10/22; -there was no documentation in the notes that a second staff was present during the walks.	V 296	This concern was previously presented in an informal appeal in October 2018. The concern was based upon a ratio of 3:8 staff/client. The discussion was pointed out that during periods of travel we had concerns as to ratio being possible. Examples as follows: • 1 child becomes ill and needs transported to the doctor. This leaves 7 in the house with 2 staff members will leave both scenarios out of ratio. • 7 children are transported to an activity and 1 remains in the home sick. 7 children at the off campus activity will be out of ratio with 2 staff members and the 1 left in the home will be out of ratio with a single staff member. Of the (8) children in the facility, they attend 3 different schools each day. The transportation has been performed by a single staff member as to ensure 2 remain in the facility. During the period of this citation, the van was transporting (7) residents to the facility from volunteering at the food hub and then another group was attending career readiness training at NC Works. Due to this citation, we have suspended all volunteer efforts and career readiness training as to staffing concerns with ratio. During the informal of 2018, it was agreed upon that a statement would be placed on the PCP regarding transportation by a single staff member. This has been the practice since 2018 and still in place to this day. There was also a concern relative to our clinical peer support staff member taking single clients out of the facility to go for walks as they attend sessions. This is an Out Patient Therapy service that is NOT billed in connection with the residential Level III service. We have suspended these sessions due to the survey concern but would like this reinstated upon review of the corrective action plan. My corrective action would be to add this intervention to the PCP as “Client are encouraged to practice safety and compliance during periods of off campus clinical services.”	12/1/2022

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V 296	Continued From page 57 This deficiency is cross referenced into 10A NCAC 27G .1701 Scope for a Type A1 rule violation and must be corrected within 23 days.	V 296		
V 298	27G .1706 Residential Tx. Child/Adol - Operations 10A NCAC 27G .1706 OPERATIONS (a) Each facility shall serve no more than a total of 12 children and adolescents. (b) Family members or other legally responsible persons shall be involved in development of plans in order to assure a smooth transition to a less restrictive setting. (c) The residential treatment staff secure facility shall coordinate with the local education agency to ensure that the child's educational needs are met as identified in the child's education plan and the treatment plan. Most of the children will be able to attend school; for others, the facility will coordinate services across settings such as alternative learning programs, day treatment, or a job placement. (d) Psychiatric consultation shall be available as needed for each child or adolescent. (e) If an adolescent has his 18th birthday while receiving treatment in the facility, he may remain for six months or until the end of the state fiscal year, whichever is longer. (f) Each child or adolescent shall be entitled to age-appropriate personal belongings unless such entitlement is counter-indicated in the treatment plan. (g) Each facility shall operate 24 hours per day, seven days per week, and each day of the year.	V 298		

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V 298	Continued From page 58 This Rule is not met as evidenced by: Based on record review, observation, and interview the facility failed to coordinate educational services for 1 of 3 audited clients (Client #1). The findings are: Review on 10/12/22 of Client #1's record revealed: -Admission Date: 7/14/22 -Discharged to level II sister facility on 8/26/22 -Re-Admission to this facility on 9/21/22 -Age:16 -Diagnoses: Conduct Disorder (D/O), Disruptive Mood Dysregulation D/O, Unspecified Trauma D/O; Borderline Intellectual Functioning, Encounter for Mental Health Services for Perpetrator of Non-Parental Sexual Abuse; -Goal on Person Centered Plan (PCP) dated 7/25/22, "For me to go to school ...to get my high school diploma" Interview on 10/24/22 with Qualified Professional #2 revealed: -Client #1 was discharged on Thursday (10/20/22). Observation on 10/11/22 at 2:11PM of Client #1 at the facility revealed: -Client #1 sat in the living room of the facility on a bench watching television. Interview on 10/11/22 with the Operations Director/Behavioral Health Facilitator (OD/BHF) revealed: -"he would attend the [Adult High School] starting Monday (10/17/22);" -"when [Client #1] came to the facility ...he couldn't do online school ...the policy had	V 298	This concern presented itself due to one resident starting school on October 20, 2022. He arrived during the month of July and this was considered summer break until the first week of September. This resident had already tested into the program and was slated to start school at the beginning of the following semester. This program has shorter, more intense, schedule of 9 weeks per semester. This in comparison to the public school semester lasting 4 months. It was discussed with the survey team that his waiting until the following semester beginning would not put his academics behind in any way. They complete double the amount of work in a 4 month period as public school. His start date is decided by the Adult High School program and we have little to do with this schedule. Due to this survey, we have met with the school administration and they have agreed to offer online based credits for children that are stuck between start dates. This will be on a case by case scenario with birthdate, academic status, and Child Family team decisions weighing heavily on the decision being made. Currently, all children are served academically with none left in limbo. The new semester will begin in January 2023 with the online option being available to students.	12/1/2022

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V 298	Continued From page 59	V 298		

changed ...had to be in-person classes for 16 and above;"
-"it was [local school system]'s policy that he couldn't start in the middle of the semester."

Interview on 10/11/22 with Client #1 revealed:
-he had been at this facility for 2-3 months;
-he had lived at the sister facility, "before it was shut down;"
-a typical day consisted of " ...staying in the house, watching TV, and doing nothing;"
-"haven't done school since I've been here...wasn't in school at [sister facility] either."

Interview on 10/13/22 with Client#1's guardian revealed:
-She believed that Client #1 had to wait to take a placement test to get in to school;
-Client #1 was supposed to be doing online school work while waiting to get in to school.

Review on 10/19/22 of Daily Notes for Client #1 from 8/1/22 to 8/25/22 and 9/16/22 to 10/9/22 revealed:
-there was no documentation regarding Client #1 attending any kind of tutoring or completing academic work.

Interview on 10/25/22 with the Operations Director/Behavioral Health Facilitator (OD/BHF) revealed:
-Client #1's tutoring was informal and documentation would be in the daily notes.

Interview on 10/24/22 with Qualified Professional #2 (QP #2) revealed:
-there were two semesters at the Adult High School and Client #1 had missed the start of the semester;
-while they wait for the new semester, he reported

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V 298	Continued From page 60 that clients don't engage in academics until the next semester starts; -"...the facility was trying to find a good spot for the 9th graders and [Client #1] didn't fit ..." Interview on 10/12/22 and 10/25/22 with the Administrator revealed; -when Client #1 came to the facility, it was the summer; -"[Client #1] couldn't start the [Adult High School] because he wasn't 16 yet and had to wait till the new semester started;" -"[Client #1] turned 16 the first week of September so there was about a month or so we were waiting for him to start;" -"[Client #1] should have been getting help with academics or tutoring... and it should be in the daily notes." This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 298		
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	V 367		

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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 incidents involving a client death to the Division of

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V 367	Continued From page 62 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 review and interviews the facility failed to submit level II incidents to the Local Management Entity/Managed Care Organization (LME/MCO) as required. The findings are:	V 367		

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V 367	Continued From page 63 Review on 10/11/22, 10/12/22, and 10/17/22 of facility incident reports revealed: 8/3/22: Level II, a resident approached Qualified Professional #2 at a sister facility and made allegations about sexual behavior between two clients while at the facility, (Client #1 and Former Client #11) 9/14/22-Level II, "[Client #4] disclosed to direct care staff that member he was concerned about another client (Client #1) returning to Level 3 ... [Client #4] shared [Client #1] had performed oral sex on him ...said that this was a dare by another client for this action to take place." Review on 10/18/22 and 10/19/22 of Facility Daily Notes from 8/1/22 to 10/14/22 for Client #2 revealed: -8/31/22: became physically aggressive when another client was being discharged; "He began kicking the walls and became physically and verbally aggressive ...left the facility without permission ...Law Enforcement found [Client #2] at another facility and was transported home." Review on 10/11/22 and 10/19/22 of the North Carolina Incident Response Improvement System (IRIS) of facility incident reports revealed: -7/5/22: Level II incident, physical aggression, Client #2 and Client #4 physically assaulted another client who had returned from the hospital from Involuntary Commitment (IVC) and began making comments, submitted to IRIS on 8/8/22; -8/8/22 Level II incident, physical aggression,4:00PM, Client #2 physically assaulted Client #1 by picking him up by the back of the neck, submitted on 8/12/22; -8/13/22 Level II incident, Elopement (Former Client #9), law enforcement called; submitted	V 367		

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V 367	Continued From page 64 8/17/22; -8/22/22 Level II incident, Former Client #10 had a " medical episode, Emergency Management System (EMS) was called, and he was cleared medically;" -this incident was submitted on 8/26/22; -9/16/22 Level II incident, (incident occurred on 9/14/22), "[Client #4] made allegations that [Client #1] had performed oral sex on him as a dare ....provider update on 9/21/22 investigation concluded ...both clients admitted that it was consensual ...submitted to IRIS 9/19/22 and update on 9/21/22;" -9/29/22 Level II incident, "7:30AM...[Client #5] was arguing with [Client #8] about food ....went into his room and punched him in the face, causing a bloody nose and cutting the inside of [Client #8's] lip;" submitted 10/3/22. -the 8/3/22 and 8/31/22 Level II incidents were not submitted in the IRIS system. Interview on 10/13/22 with BHD/QP #1 revealed: -he was responsible for reviewing and submitting incident reports; -prior to September 2022 he was putting incident reports into IRIS; -there were some incidents that were not submitted in IRIS timely. Interview on 10/25/22 with the Administrator revealed: -incident reports had been an issue the past; -in September 2022, incident reports were being entered by another staff to help BHD/QP#1 and should no longer be a problem. This deficiency has been cited three times on 7/24/20, 12/13/21, and 7/6/22. This deficiency constitutes a recited deficiency	V 367	This concern has developed on several occasions regarding reporting incidents to the IRIS system. It has been noted that the IRIS system is very cumbersome to navigate and very little training opportunities exist to ensure proper utilization of this platform. We have reached out to Vaya and they are working with us to ensure our QPs responsible for submission to IRIS are properly trained in utilization. I have also began requiring screen shots of the “THUMBS UP” icon to ensure that the submission was successfully transmitted in the first place. The IRIS system provides a confirmation number at some point but this still doesn’t constitute that the submission went through completely. This was an issue that was overlooked by administration because of reviewing the case file revealed a screenshot of the confirmation but not the “thumbs up” icon. This expectation and submission of the IRIS within 72 hours of the incident is currently in place.	12/1/2022

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V 367	Continued From page 65 and is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 367		
V 513	27E .0101 Client Rights - Least Restictive Alternative 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports that promote a safe and respectful environment. These include: (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include: (1) using the intervention as a last resort; and (2) employing the intervention by people trained in its use. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to use the least restrictive and most appropriate settings and methods affecting 3 of 3 audited clients (Clients #1, #2 and #3). The	V 513		

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V 513	Continued From page 66 findings are: Observation at 2:30PM on 10/11/22 revealed: -the facility's kitchen was located at the end of the hallway on the left side; -there was a sign on the door that said "Staff only. Residents are not allowed in the kitchen;" -there was a key code lock on the door restricting access by clients to the kitchen. Interview on 10/11/22 with the Operations Director/Behavioral Health Facilitator revealed: -the kitchen had always been locked; -snacks were at 10:00AM, lunch was at 12:00PM, snack at 2:00PM and the 7:00PM snack was fruit because "we don't want them to get all sugared up." Interview on 10/11/22 with Client #1 revealed: -they were not allowed to go into the kitchen; he "heard that in the past some level 3 kids would go in there and steal food;" -"since they found out about the state, they started stocking up on the food. The food was good either way"; he was getting enough to eat but "now there are more snacks and dinner;" -if he was hungry during the day, "can't get another snack." Interview on 10/11/22 with Client #2 revealed: -snacks were at 10:00AM, 2:00PM, and 7:00PM; -"if you're hungry, you have to wait." Interview on 10/11/22 with Client #3 revealed: -there were only certain times of the day that he could get a snack; he got hungry during the day; -if he was hungry, "you have to wait until snack time." Interview on 10/17/22 with Direct Support	V 513		

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V 513	Continued From page 67 Professional #3 revealed: -the kitchen was locked, "if we just let them in there, all the stuff would be missing;" -if clients asked for a snack, he gave it to them; "probably not the answer they want me to give;" -they (clients) "always get the code, we always have to change it." Interview on 10/24/22 with the Associate Professional (AP) revealed: -the kitchen was locked; it was a safety concern; -they were "binge eating issues with kids in the past;" -"always had the kitchen locked at level 3." Interview on 10/12/22 and 10/20/22 with the Administrator: -the kitchen was locked and "it's always been locked" -snacks were in the office; they had 10:00AM, 2:00PM, and 7:00PM snacks. -clients took the 10:00AM and 2:00PM snacks with them to school; -meal choice was considered on the weekend but not during the week; -he "used to let the kids come eat whenever and they would clean" him out; -he "used to give kids $80 to spend on snacks but kids were eating through it too fast." This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 513	Clear Sky Behavioral keeps the kitchen locked at all times in facilities that allow the area to be secured. This is an effort to remove clients from areas of sharp objects in a mental health treatment program. Due to the concern of healthy snacks, we are currently leaving a fruit basket out in accessible areas for clients to have healthy snacks at all times of the day. This was a compromise to leaving the kitchen open and the risk of danger that presents itself in a facility. This action was implemented immediately.	12/1/2022
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON	V 536		

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V 536	Continued From page 68 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 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	V 536		

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V 536	Continued From page 69 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 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	V 536		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEAR SKY GROUP HOME	55 RAILROAD STREET MARION, NC 28752

(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 536	Continued From page 70	V 536		

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 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

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V 536	Continued From page 71 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 record reviews and interviews, the facility failed to ensure 1 of 6 audited staff (Direct Support Professional #2 (DSP #2)) had completed annual refresher training in alternatives to restrictive interventions prior to providing services. The findings are: Review on 10/12/22 of DSP #2's record revealed: -Date of hire: 9/27/21 -Position: Behavioral Health Technician -NCI+ (Non-violent Crisis Intervention), Preventive and Defensive training had expired 9/20/22. Interview on 10/20/22 with the Administrator revealed: -he planned to schedule an NCI training for staff. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 536		

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V 537	Continued From page 72	V 537		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to	V 537		

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V 537	Continued From page 73 Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the	V 537		

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V 537	Continued From page 74 need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once	V 537		

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V 537	Continued From page 75 annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that 3 of 6 audited staff (Direct Support Professional (DSP) #2, #3 and the Behavioral Health Specialist/Peer Support Specialist (BHS/PSS)) had training in seclusion, physical restraint, and isolation time-out prior to providing services. The findings are: Review on 10/12/22 of DSP #2's record revealed: -Date of hire: 9/27/21 -Position: Behavioral Health Technician	V 537		

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V 537	Continued From page 76 -no documentation that she was trained in restrictive interventions. Review on 10/12/22 of the DSP #3's record revealed: -Date of hire: 8/11/22 -trained in NCI+ (Non-violent Crisis Intervention) Preventive and Defensive on 8/11/22; -no documentation that he was trained in restrictive interventions. Review on 10/20/22 of the BHS/PSS's record revealed: -Date of Hire: 5/2/22 -Position: Peer Support Specialist -there was no documentation that she was trained in restrictive interventions. Review on 10/17/22 of the facility's restrictive intervention policy revealed: -"Clear Sky Behavioral, LLC (licensee) governance committee has adopted the National Crisis Interventions (+) therapeutic wrap and bear hug techniques as the ONLY approved restrictive intervention." Review on 10/13/22 and 10/17/22 of the Person Centered Plan and Crisis Prevention/Intervention Plans for Client #1, Client #2, and Client #3 revealed: -"Provider Interventions" for each goal included "When necessary, utilize the NCI+ Interventions to assist de-escalation and debrief after episodes of dysregulations;" -"Specific recommendations for interacting with the person during a crisis: If Client becomes an increased danger to himself or others Staff may utilize NCI techniques. If Staff are unable to safety utilize NCI+ Program or Client becomes unable to de-escalate call 911."	V 537		

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V 537	Continued From page 77 Interview on 10/17/22 with DSP #3 revealed: -he was supervised by the Operations Director/Behavioral Health Facilitator (OD/BHF); -there were two times he had to intervene physically; -one incident when Client #1 and Client #5 were sitting at the dining room table doing virtual group therapy and Client #1 was "antagonizing" Client #5; -Client #5 "went in on" Client #1 and he had to "pull them apart;" -"it was happening in such a tight space ...couldn't wedge in;" he pulled them apart and "we all fell over;" -"pulled them by the shoulders, we lost balance, and all fell ...that's when they separated." -he took Client #5 to the back of the building and the Associate Professional (AP) took Client #1 to the front of the building; -he did not complete an incident report; he assumed "someone else was doing it;" -the second incident was he had to "pull" Client #2 off Client #7; Client #7 was "coming at" Client #2 and Client #2 was pressing Client #7's hands against the wall; -he had NCI training on his first day (8/11/22). Interview on 10/11/22 with Client #1 revealed: -"[Client #5] got in to a fight with me ...he wanted to swing on me ...he wanted to start something ...he did the same thing to another kid, busted his lip and punched his face a couple times." Interview on 10/24/22 with Client #5 revealed: -he didn't want to talk about what happened with Client #1; Interview on 10/24/22 with the AP revealed: -she was present when DSP #3 intervened with	V 537		

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V 537	Continued From page 78 Client #1 and Client 5; she walked down the hallway and saw DSP #3 and Client #5 on the floor; -she took Client #1 outside and DSP #2 took Client #5 to the back of the facility; -there were no injuries; -unaware if an incident report was made, "if so, [BHD/QP#1] would have done it." Interview on 10/13/22 with the QP#1/BHD revealed: -there were several male staff trained in restrictive interventions; he did not have the list in front of him. -"the worry is with the younger kids." Interview on 10/12/22 and 10/20/22 with the Administrator revealed: -he only trained the staff he trusted in restrictive interventions "who wouldn't go overboard;" -he didn't want female staff "wrestling" with male clients; -if he trained all the staff, they "would be restraining left and right;" -in 5 years, there were "maybe 5 or 6 restraints;" -the only approved holds were the bear hug and therapeutic wrap; -the Operations Director/BHF was one of the female staff who was trained. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 537	Clear Sky Behavioral, for many years, practiced a "block and move" policy and didn't authorize any restrictive type interventions. We recently implemented in policy that staff could be trained in restrictive interventions to help alleviate the overuse of police involvement for certain circumstances. Within the Clear Sky Behavioral policy it stated that 3 circumstances allowed the use of restrictive interventions for employees trained to provide this extra measure of safety within the facility. 1) Self Harm, (2) Physical Confrontation or Assaultive Behaviors, (3) Elopement, when the age of the child or cognitive ability of the child presents a danger to them. We train all employees in NCI Prevention and Defensive Interventions but purposely did not train every employee in the ability to utilize restrictive interventions. This is a measure that we only felt comfortable utilizing with seasoned and capable staff. We felt our female staff could become injured or some staff may go to far with the restrictive intervention. We felt it would be our choice as to who we would authorize to utilize restrictive interventions. Nonetheless, after this survey, we have trained 100% of our staff in the use of restrictive interventions. At this point all Level III staff will be trained in NCI Prevention, Defensive, and Restrictive measures.	12/1/2022
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS	V 736		

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V 736	Continued From page 79 (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 was not maintained in a safe, clean, attractive, and orderly manner. The findings are: Observation on 10/7/22 at 12:09pm of the facility revealed: -in the backroom hallway by the facility exit, there was wood paneling, a metal rail, PVC board, plywood and laminate flooring up against the wall; -the baseboard and wall near the client bathroom was scuffed, had brown marks, and the paint was chipped; -the painted fiberboard base of the sink in the client bathroom was peeling; -the concrete shower floor had large brown stains around the drain; -there was a brown substance in the seams around the shower base; -the client shower room had two fist sized holes in the wall that were unpainted; -there was a missing top drawer on the left side of the stove, in the kitchen; -there was missing sheetrock above the kitchen door where a camera had been placed; -there were small white circular paint stains on the carpet throughout the facility; -there was a visible gap between the window air conditioner unit and window in first client bedroom on the right; -ceiling tiles were stained brown throughout the	V 736		

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V 736	Continued From page 80	V 736		

facility in client bedrooms and ripped;
-a ceiling tile next to fluorescent light in the living room was not flush in its placement;
-12:12PM, Client #1 asked for paper towel;
-12:12 PM, there were no paper towels observed in the bathroom or toilet paper in the holder;
- the hallway was missing some wood paneling in areas.

Observation and interview with the Operations Director/Behavioral Health Facilitator (OD/BHF) on 10/11/22 at 2:30 pm of the facility revealed:
-a four-bedroom facility, with two single beds per room;
-the carpet was stained brown and black throughout the facility and torn in client bedroom areas and hallway;
-the first client bedroom on the left had pink, black, and white stains on the carpet;
-the second bedroom on the left had a ripped ceiling tile with a vent in the corner;
-the dining area/"multi-purpose" room had heavily soiled carpet with black marks and ceiling tiles that were ripped;
-baseboards in the dining room/multi-purpose room were scuffed, missing paint, and dirty with brown marks;
-the client bathroom had toilet paper on the floor;
-the door frame was damaged and ripped in the second bedroom to the right;
-the picnic table to the side of the facility had nails sticking up from the table area;
-ceiling tiles were ripped or damaged throughout the facility;
-the facility had silver duct tape on the carpet in front of each client bedroom that outlined a boundary of how far each client could go;
-the carpet had always looked this way;
-the Administrator wanted to put plank flooring in the facility.

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V 736	Continued From page 81 Interview on 10/14/22 with Division of Health Service Regulation (DHSR) construction staff revealed: -they have a plan of correction with the facility; -the carpet needed to be cleaned or replaced; -the ceiling tiles need to be flush in their placement. Interviews from 10/11/22 to 10/25/22 with the Administrator revealed: -he had a full-time maintenance man working at his facilities; -he'd never replaced the carpet in the facility; -he reported that it was a "4-day job" to put in the new flooring and didn't have anywhere for the kids to go; -the kids tore up the living room furniture and that's why he had benches in the living room. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 736	This facility is a Level III facility and takes a lot of abuse from the clients served. We have a full time repair man that repairs holes in the walls and doors that have been broken from the hinges. These are common response when this population is faced with "NO" as a staff response to something they want. Based on this audit and a further audit conducted by DHSR Construction section, we have replaced all flooring in the home with vinyl plank style flooring. This is a very durable option and will last for many years. The HVAC has also been upgraded to mini-split units in each of the living areas. The suspended ceiling tiles have been replaced or repaired to ensure no air gaps exists in the roof membrane. All doors properly close and all walls have been patched. This critical area will need more time than 23 days to complete as DHSR construction had given a timeline of 45 days from the date of deficiencies are received. However, the cosmetic areas noted by the DHSR Surveyors has already been corrected.	12/1/2022