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V 000	INITIAL COMMENTS A complaint survey was completed on November 21, 2022. The complaint (Intake #NC00194708) was substantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents This facility is licensed for 4 and currently has a census of 4. The survey sample consisted of audits of 3 current clients.	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and	V 110		

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V 110	Continued From page 1 (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 5 paraprofessional staff (#1) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are: Review on 11/17/22 of staff #1's record revealed: -A hire date of 8/31/22 -A job description of Paraprofessional -Client specific training completed on 8/31/22 -Evidenced Based Protective Intervention-Base Plus completed on 1/29/22 Review on 11/17/22 of client #1's record revealed: -An admission date of 2/28/22 -Diagnoses of Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder, Combined Presentation -Age 15 -An assessment dated 2/11/22 noted "was transferred from a PRTF from a group home where he had been for less than 1 year. Was referred from his placement due to chronic, but worsening aggression in the setting, has a lot of problems getting angry and can get verbally and physically aggressive at times when frustrated, has been noted to escalating to hitting, kicking and spitting, history of property destruction,	V 110		

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V 110	Continued From page 2 history of poor impulse control, poor adaptability and frustration tolerance than any cyclical mood pathology, becomes very emotional in stressful situations to a greater extent that would be expected for his developmental level, was a victim of neglect and physical abuse, he endorses trauma, intrusive memories and some nightmares, needs to learn to communicate in a positive manner and be able to discuss his frustration and anger without being aggressive, has peer conflicts, poor physical boundaries, manipulates others, provokes and instigates others, history of bullying, conflict with caregivers and authority figures, he does not like confrontation, struggles with using coping skills and does not always share his emotions or feelings." -An updated treatment plan dated 4/20/22 noted "will explore his emotions relevant to the trauma he has been exposed to in order to develop better coping skills that will help him improve his behaviors so he can maximize his fullest potential, will complete his personal hygiene, chores and cleaning up after himself as expected with two prompts max from staff, will complete it correctly with zero need for redirection to complete it appropriately and will ask staff for assistance if he is unsure how to do so, will learn to demonstrate the ability to communicate effectively with school staff, his family, authority figures and peers by talking in an appropriate manner being able to express his feelings, being able to share personal details without losing his temper and getting aggressive/disrespectful 90% of the time, receives therapy weekly in the level III setting, receives medication management, is working on coping skills and working through past trauma." Finding #1	V 110		

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V 110	Continued From page 3 Review on 11/17/22 of the facility's level I incident report and internal investigation, completed by the Qualified Professional/Licensee (QP/L), revealed: -The QP/L learned of the incident on 11/3/22 when the school called to report the incident -"On 11/2/22 at 7:30pm, staff (#1) and client (#1) were in the kitchen. Staff was asking client to complete his chores. Client told staff he wasn't doing his chore because he was on restriction from the day before. Client stated that he wasn't doing his chore because he wasn't getting his allowance nor points. Staff tried to explain to client that he does get his allowance just not points due to restrictions. Staff attempted to explain again. Client refused to listen. Staff then instructed client if he wasn't going to do his chore, he could go to his room. Client went to his room, slammed the door and begun banging on the wall. Staff entered client's room and asked client what was going on. Client continued hitting the wall. Client then grabbed a little lamp and threw it. Client then grabbed a heavier lamp from the nightstand and attempted to throw it. Staff intervened and placed client in a therapeutic EBPI (Evidence Based Protective Intervention) hold. That is when client released the lamp. Client and staff fell to the bed as staff was attempting to use therapeutic hold. Staff was instructing client to calm down. Client then pulled his mattress of his bed and laid on the floor under his mattress. Staff left the room. Staff returned 15 minutes later to check on client. Client appeared to be asleep on the floor. Staff allowed client to remain on the floor asleep. Staff did another check 15 minutes later. Client had put his mattress back on the bed and appeared to be sleeping in his bed for the remainder of the shift." Observation and interview on 11/17/22 at 4:45pm with client #1 revealed:	V 110		

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V 110	Continued From page 4 -Got into an argument with staff #1 over doing his chores -Went to his room to calm down and started stomping his feet -Staff #1 told him to stop stomping his feet -"I stopped and then started stomping my feet again. [Staff #1] got mad because I made an extra noise. He got in my face, and I asked him two times to get out of my face. We were arguing and I put my arms out and pushed him. He pushed my arms away by the wrists. He pushed me on the bed. He grabbed my right arm and had his other hand here (demonstrated a hand on his clavicle bone). It was supposed to be a restraint, but it wasn't. He did not choke me. I used my other hand to move his hand. It only lasted about 5 or 10 seconds ...when I went to school the next day (11/3/22), I told them I was not coming home. My teacher called [the QP/L] and he took [staff #1] off the schedule for over a week ..." Observation and interview on 11/17/22 at 9:12m with client #2 revealed: -There was an incident between client #1 and staff #1. -"A lady from social services came out and talked to us. [Client #1] was saying he got restrained. He was flipping out. I was in the living room. The other clients (#3 and #4) were there too. I think they were in the kitchen with [staff #2]." -Demonstrated a therapeutic wrap when asked what the restraint looked like. -Denied seeing any marks on client #1 -"[Staff #1] told him to sit down and to calm down. [Client #1] then went to his room. When he got to his room, he threw his mattress, threw his drawers (dresser) and other stuff at the staff. [Staff #1] was just telling him to calm down. He wasn't harming him or anything. He just told him to calm down."	V 110		

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-The other staff working that day (11/2/22) was staff #2
-Staff #1 did not work for a week after the incident occurred.
-"He (staff #1) is back now and he and [client #1] are cool now. [Client #1] apologized. He was bragging at the dinner table that he had lied on staff, trying to get him fired and get the group home shut down ..."

Interview on 11/17/22 with client #3 revealed:
-Had never really heard or seen staff #1 try to actively harm any of the clients.
-On 11/2/22, "I was sitting and eating dinner at the table. I wasn't paying attention enough to give you specifics as I was listening to music on my headphones. [Client #1] was agitated and [staff #1] was trying to redirect him. That's all I know ..."
-"The next night (11/3/22) at the table, [client #1] described being grabbed around the throat and thrown on the bed by [staff #1] ...I never saw any marks on him ...[client #1] is known to tell false truths ...that's all he ever said to me. Nothing else ...usually [client #1] will make up things when he doesn't get his way ..."

Interview on 11/17/22 with client #4 revealed:
-"[Client #1] got mad and threw stuff at [staff #1] while he was in his room. He kept throwing stuff even after the staff left his room and kept doing it when staff left his room."
-A social worker came out and interviewed him about the incident.
-"The social worker said a kid was getting hurt here. I was present (on 11/2/22) and doing my chore of cleaning the hallway. Both [staff #1] and [staff #2] were present. All I know is [client #1] got in an argument with [staff #1] because he wasn't getting paid for his chores because he was on restriction. No one put their hands on him. I did

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V 110	Continued From page 6 not see any marks ..." Interview on 11/18/22 with the investigating social worker revealed: -"So, I did interview the children. The only ones in the room whenever the incident occurred was [client #1]. The other clients were not in the same room. The staff (#2) said he had to restrain [client #1] because he was damaging furniture. He did restrain him but denied putting his hand on [client #1]'s neck. When I interviewed [client #1], he stated [staff #1] held his arm down and then used his other hand to hold him down by the neck. I did not see any injuries. The other children stated they had been restrained, but not in an inappropriate manner. [The QP/L] said that staff had years of experience working with children and had never had any complaints on him. He did take that staff off the schedule. I am assuming the staff is still off the schedule. I have a visit with them today (11/18/22) ..." Interview on 11/18/22 with staff #1 revealed: -"On 11/2/22, [client #1] was on restriction from the previous day (11/1/22) due to an incident that occurred at school. He was supposed to wash the dishes but refused because he said he would not get his chore pay. I explained to him that he would get his chore pay but would not get points. He stated again he was not going to wash the dishes, so I told him to go to his room." -When client #1 went to his room, he started banging on the walls. -"I went in to check on him and to process with him to see why he was having these behaviors. I stood at the door and watched him. When I asked him why he was doing things, he picked up a white lamp and slung it at me. Then he picked up a heavier lamp. I grabbed this lamp from him and he started screaming. I grabbed a chair and sat	V 110		

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and watched him. I sat in the doorway. He kept stomping his feet on the floor."
-After awhile, client #1 sat on the floor and pulled his covers and mattress on the floor and went to sleep.
-When asked for clarification about the incident with the heavier lamp, staff #2 stated "the only conflict we had was when I tried to grab the lamp from him. I grabbed the lamp with one hand and pushed [client #1] with my other hand. He fell on the bed. I pushed him under the arm pit area. I separate the lamp from him but not restrain him. It was not a big tussle. I just grabbed the lamp he was trying to throw at me and pushed him away from me."

Interview on 11/17/22 with staff #2 revealed:
-Was working the day of the incident
-"We (staff #1 and staff #2) told him (client #1) to do the dishes. He was already on restriction for getting trouble at school. He said he wasn't doing it He went back and forth with [staff #1]. He was told to go to his room. When he got there, he started throwing stuff. [Staff #1] went to check on him and I stayed with the other clients. I heard [staff #1] and [client #1] screaming at each other. They were talking over one another. That doesn't work for [client #1]. He needs space to calm down, so I ask him to go to his room ..."
-Had not seen any marks or injuries to client #1.
-"I just saw his room and it was dirty from throwing stuff around. His covers were on the floor, toys and shoes everywhere and mattress off the frame. He cleaned it up and came out and there were no other issues that night."
-A social worker came out to the facility on 11/3/22.
-"She interviewed me and [client #1] about what happened. Apparently, [client #1] stated he was restrained, but I did not see anyone get

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restrained. We are all trained in EBPI. There were 2 officers that came out and they only interviewed [client #1]. I am not sure of the outcome ..."
-Staff #1 was taken off the schedule for a week before he returned to work.

Interview on 11/17/22 with the QP/L revealed:
-"[Client #1] made an allegation that [staff #1] held him down and that the staff had him by the neck. He made the allegation either on a Wednesday or Thursday. It may have been Wednesday as [staff #1] was scheduled to return to work on Thursday ...the police and a social worker came out to talk to [client #1] as he told the school that he was not returning to the facility ...I learned about the allegation on 11/3/22 and I immediately took [staff #1] off the schedule for a week ...
-Staff #1 had been trained on client #1's treatment plan and triggers

Finding #2
Interview on 11/17/22 with client #1 revealed:
-Had gotten into an argument with staff #1 over completing chores
-"He got in my face and yelled at me. I told him two times to get out of my face ..."

Interview on 11/17/22 with client #3 revealed:
-When discussing staff #1 and any issues, client #3 stated "The farthest it has every gone was a gentle reminder that I needed to get back on task. I had one minor conversation that could be viewed as slightly aggressive ...I was frustrated with him. I walked from the bathroom to my room, and he got on my case. It's not often when he gets upset. When he has given prompts, he gets agitated that we are not following his prompts. We are expected to follow the rules. We all have feelings and make mistakes ..."

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V 110	Continued From page 9 Interview on 11/17/22 with client #4 revealed: -" ...I do know that [staff #1] matched [client #1]'s energy and was raising his voice trying to get his attention...if someone raises their voice, [staff #1] will match their energy. It helps them realize how loud they are and to calm down ...only [staff #1] does that ..." Interview on 11/18/22 with staff #1 revealed: -Had been trained on de-escalation techniques -Admitted to raising his voice to the clients at the facility -"That has only happened maybe three times. I have screamed and gotten to that level to show them how loud they are. I raise my hands up and lower them so we can have a conversation that does not involve yelling." -Was not trained to scream or raise his voice at the clients as part of a de-escalation technique. -"I know that is not therapeutic to yell or raise my voice. I don't do it to intimidate them. I am sorry about it." Interview on 11/17/22 with staff #2 revealed: -Things that helped client #1 calm down including "sending him to his room, taking him to the park, allowing him to play his game. When he has time to think about things, that's when he gets carried away ...keeping him busy works best when trying to calm him down ..." -Had heard staff #1 raise his voice to the clients -" ...I don't think that's therapeutic ...I have heard him yell at the clients in the past ..." Interview on 11/21/22 with the QP/Licensee revealed: -No one had ever complained about staff #1 about his interactions with the clients -Staff #1 had a lot of experience working with the	V 110		

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V 110	Continued From page 10 population -Staff #1 had been tried on the clients' treatment plans, diagnoses and de-escalation techniques	V 110		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.	V 132		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to report allegations of abuse to the Health Care Personnel Registry (HCPR). The findings are:

Review on 11/17/22 of the facility's level III incident reports revealed:
-No documentation the HCPR was notified of an allegation of abuse by staff #1 which occurred on 11/2/22

Review on 11/17/22 of the facility's level I incident report, completed by the Qualified Professional/Licensee (QP/L), revealed:
-"On 11/2/22 at 7:30pm, staff (#1) and client (#1) were in the kitchen. Staff was asking client to complete his chores. Client told staff he wasn't doing his chore because he was on restriction from the day before. Client stated that he wasn't doing his chore because he wasn't getting his allowance nor points. Staff tried to explain to client that he does get his allowance just not points due to restrictions. Staff attempted to explain again. Client refused to listen. Staff then instructed client if he wasn't going to do his chore,

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he could go to his room. Client went to his room, slammed the door and begun banging on the wall. Staff entered client's room and asked client what was going on. Client continued hitting the wall. Client then grabbed a little lamp and threw it. Client then grabbed a heavier lamp from the nightstand and attempted to throw it. Staff intervened and placed client in a therapeutic EBPI (Evidence Based Protective Intervention) hold. That is when client released the lamp. Client and staff fell to the bed as staff was attempting to use therapeutic hold. Staff was instructing client to calm down. Client then pulled his mattress of his bed and laid on the floor under his mattress. Staff left the room. Staff returned 15 minutes later to check on client. Client appeared to be asleep on the floor. Staff allowed client to remain on the floor asleep. Staff did another check 15 minutes later. Client had put his mattress back on the bed and appeared to be sleeping in his bed for the remainder of the shift."

Observation and interview on 11/17/22 at 4:45pm with client #1 revealed:
-Got into an argument with staff #1 over doing his chores
-Went to his room to calm down and started stomping his feet
-Staff #1 told him to stop stomping his feet
-"I stopped and then started stomping my feet again. [Staff #1] got mad because I made an extra noise. He got in my face, and I asked him two times to get out of my face. We were arguing and I put my arms out and pushed him. He pushed my arms away by the wrists. He pushed me on the bed. He grabbed my right arm and had his other hand here (demonstrated a hand on his clavicle bone). It was supposed to be a restraint, but it wasn't. He did not choke me. I used my other hand to move his hand. It only lasted about

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(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 132	Continued From page 13 5 or 10 seconds ...when I went to school the next day (11/3/22), I told them I was not coming home. My teacher called [the QP/L] and he took [staff #1] off the schedule for over a week ..." Interview on 11/18/22 with staff #2 revealed: -There was an incident on 11/2/22 between him and client #1 -Client #1 had refused to complete his chore and was sent to his room -While client #1 was in his room, he started banging on the walls, stomping his feet and picked up a lamp. -"The only conflict we had was when I tried to grab the lamp from him. I grabbed the lamp with one hand and pushed [client #1] with my other hand. He fell on the bed. I pushed him under the arm pit area. I separate the lamp from him but not restrain him. It was not a big tussle. I just grabbed the lamp he was trying to throw at me and pushed him away from me." -Denied there was anything else to the incident. Interview on 11/17/22 with the QP/L revealed: -"[Client #1] made an allegation that [staff #1] held him down and that the staff had him by the neck. He made the allegation either on a Wednesday or Thursday. It may have been Wednesday as [staff #1] was scheduled to return to work on Thursday ...the police and a social worker came out to talk to [client #1] as he told the school staff he was not returning to the facility ...I learned about the allegation on 11/3/22 and I immediately took [staff #1] off the schedule for a week ...since I did not see any marks on [client #1] and the police did not charge anyone, I didn't report the incident to the HCPR ...I did complete an internal investigation though." -Asked this surveyor if he should make a report to	V 132		

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V 132	Continued From page 14 the HCPR today (11/17/22).	V 132		
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 (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	V 296		

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V 296	Continued From page 15 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 observation, record reviews, and interviews, the facility failed to ensure at least two direct care staff were present when one, two, three or four adolescents were present affecting 3 of 3 audited clients (#1, #2 and #3). The findings are: Observations on 11/17/22 from 8:42am to 9:12am revealed: -The Qualified Professional/Licensee (QP/L) was present at the facility with client #2. -There were no other staff at the facility. Further observations on 11/17/22 at 9:12am revealed: -Staff #2 arrived at the facility Review on 11/17/22 of client #1's record revealed: -An admission date of 2/28/22 -Diagnoses of Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder, Combined Presentation -Age 15 -An assessment dated 2/11/22 noted "was transferred from a PRTF from a group home	V 296		

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V 296	Continued From page 16 where he had been for less than 1 year. Was referred from his placement due to chronic, but worsening aggression in the setting, has a lot of problems getting angry and can get verbally and physically aggressive at times when frustrated, has been noted to escalating to hitting, kicking and spitting, history of property destruction, history of poor impulse control, poor adaptability and frustration tolerance than any cyclical mood pathology, becomes very emotional in stressful situations to a greater extent that would be expected for his developmental level, was a victim of neglect and physical abuse, he endorses trauma, intrusive memories and some nightmares, needs to learn to communicate in a positive manner and be able to discuss his frustration and anger without being aggressive, has peer conflicts, poor physical boundaries, manipulates others, provokes and instigates others, history of bullying, conflict with caregivers and authority figures, he does not like confrontation, struggles with using coping skills and does not always share his emotions or feelings." -An updated treatment plan dated 4/20/22 noted "will explore his emotions relevant to the trauma he has been exposed to in order to develop better coping skills that will help him improve his behaviors so he can maximize his fullest potential, will complete his personal hygiene, chores and cleaning up after himself as expected with two prompts max from staff, will complete it correctly with zero need for redirection to complete it appropriately and will ask staff for assistance if he is unsure how to do so, will learn to demonstrate the ability to communicate effectively with school staff, his family, authority figures and peers by talking in an appropriate manner being able to express his feelings, being able to share personal details without losing his	V 296		

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temper and getting aggressive/disrespectful 90% of the time, receives therapy weekly in the level III setting, receives medication management, is working on coping skills and working through past trauma."

Review on 11/17/22 of client #2's record revealed:
-An admission date of 3/14/22
-Diagnoses of Oppositional Defiant Disorder, Moderate and Alcohol Use Disorder, Mild
-Age 15
-An assessment dated 3/14/22 noted "has significant risk of harm, recommends a level III residential placement that offers more structure, participate in therapy to address symptoms of anger, defiance, and substance use, demonstrates behaviors of anger and disruption of the home environment, department of juvenile justice and legal involvement and would benefit from an out of home placement."
-An updated treatment plan dated 7/14/22 noted "will learn to use stop and think skills instead of arguing, learn strategies for staying positive, will identify three negative effects of alcohol, develop and follow a relapse plan."

Review on 11/17/22 of client #3's record revealed:
-An admission date of 8/31/22
-Diagnoses of Major Depressive Disorder, Recurrent Episode, Moderate, Post Traumatic Stress Disorder, Oppositional Defiance Disorder, Gender Dysphoria, in Adolescents and Adults, Child Neglect, Confirmed, Subsequent Encounter, Child Sexual Abuse, Suspected, Subsequent Encounter.
-Age 17
-An assessment dated 8/31/22 noted "Was previously placed at a PRTF, recommended step down to a level III residential group home, has made progress in communicating his needs and

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V 296	Continued From page 18 concerns, struggles with impulsivity and social interaction, needs structure and consistency, needs to improve his independent living skills, history of property destruction and aggression, needs access to group therapy for emotional regulation, needs empathy development, increased impulse control management and skills, safety planning for specific environments, development and practice of appropriate and healthy physical, social and emotional boundaries, anger management, conflict resolution and problem solving skills, moral reasoning, healthy arousal management and accountability and medication management." -A treatment plan dated 8/17/22 noted "will step down from a PRTF and transition to a level III group home where he will follow the rules and expectations, participate in therapy as indicated and take his medication as prescribed, will continue to practice utilizing non-material coping skills to help him manage impulsivity and compliance as evidenced by demonstrating increased use of relaxation skills at least 4 out of 7 days per week, will engage in age-appropriate social interactions and learn to communicate thoughts and emotions in a socially redeeming nature by demonstrating positive verbal and non-verbal communication with peers and staff at least 4 out of 7 days per week, will take medication as directed and appropriately seek medical care when necessary." Interview on 11/17/22 with client #1 revealed: -"There are usually two or three staff on every shift except 3rd shift. Then there is only one staff working. Last night [staff #1] was working ..." Interview on 11/17/22 with client #2 revealed: -The QP/L was the only staff present with him at the facility	V 296		

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V 296	Continued From page 19 -Did not know where the other staff was -"Usually there is just one staff on 3rd shift. That staff takes us to school. Last night (11/16/22), there was only one staff working. That was [staff #1] ..." Interview on 11/17/22 with client #3 revealed: -"When I woke up this morning, there was only one staff present and he took us to school. It was [staff #1] ..." -On third shift, there was only one staff that worked. Interview on 11/18/22 with staff #1 revealed: -Was aware there were to be two staff on every shift. -Denied working alone on third shift -On 11/17/22, staff #1 worked third shift (11pm to 8am) with the QP/L -"I took three of the clients to school that morning. After I dropped them off, I went home. When I left the facility, it was just [the QP/L] and [client #2]. There was no other staff there ...I am not sure if there was a staff coming in or not ..." Observation and interview on 11/17/22 at 9:13am with staff #2 revealed: -Arrived at the group home at 9:12am -Had been called by the QP/L to return to the facility -There were to be two staff present at all times while on shift at the group home. Observation and interview on 11/17/22 at 9:05am with the Qualified Professional/Licensee (QP/L) revealed: -Was aware there were to be two staff on shift at all times. -Was the only staff present currently -Got out his cell phone and called a staff asking if	V 296		

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V 296	Continued From page 20 he could come to the facility -"There are to be two staff here at all times. I just came in this morning (11/17/22) and have been here only about 30 minutes." Further interview on 11/21/22 with the QP/L revealed: -On 11/17/22, staff #1 had just left the facility	V 296		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (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	V 367		

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missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:
(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .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

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V 367	Continued From page 22 the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to submit Level III incident reports to the Local Management Entity (LME) within 72 hours as required. The findings are: Review on 11/17/22 of the facility's level III incident reports revealed: -No documentation of a level III incident report for 11/2/22 Review on 11/17/22 of the North Carolina Incident Response Improvement System (IRIS) revealed: -No documentation of a level III incident report for 11/2/22 Review on 11/17/22 of the facility's level I incident report and internal investigation, completed by the Qualified Professional/Licensee (QP/L), revealed: -The QP/L learned of the incident on 11/3/22 when the school called to report the incident	V 367		

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V 367	Continued From page 23 -"On 11/2/22 at 7:30pm, staff (#1) and client (#1) were in the kitchen. Staff was asking client to complete his chores. Client told staff he wasn't doing his chore because he was on restriction from the day before. Client stated that he wasn't doing his chore because he wasn't getting his allowance nor points. Staff tried to explain to client that he does get his allowance just not points due to restrictions. Staff attempted to explain again. Client refused to listen. Staff then instructed client if he wasn't going to do his chore, he could go to his room. Client went to his room, slammed the door and begun banging on the wall. Staff entered client's room and asked client what was going on. Client continued hitting the wall. Client then grabbed a little lamp and threw it. Client then grabbed a heavier lamp from the nightstand and attempted to throw it. Staff intervened and placed client in a therapeutic EBPI (Evidence Based Protective Intervention) hold. That is when client released the lamp. Client and staff fell to the bed as staff was attempting to use therapeutic hold. Staff was instructing client to calm down. Client then pulled his mattress of his bed and laid on the floor under his mattress. Staff left the room. Staff returned 15 minutes later to check on client. Client appeared to be asleep on the floor. Staff allowed client to remain on the floor asleep. Staff did another check 15 minutes later. Client had put his mattress back on the bed and appeared to be sleeping in his bed for the remainder of the shift." Observation and interview on 11/17/22 at 4:45pm with client #1 revealed: -Got into an argument with staff #1 over doing his chores -Went to his room to calm down and started stomping his feet -Staff #1 told him to stop stomping his feet	V 367		

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V 367	Continued From page 24 -"I stopped and then started stomping my feet again. [Staff #1] got mad because I made an extra noise. He got in my face, and I asked him two times to get out of my face. We were arguing and I put my arms out and pushed him. He pushed my arms away by the wrists. He pushed me on the bed. He grabbed my right arm and had his other hand here (demonstrated a hand on his clavicle bone). It was supposed to be a restraint, but it wasn't. He did not choke me. I used my other hand to move his hand. It only lasted about 5 or 10 seconds ...when I went to school the next day (11/3/22), I told them I was not coming home. My teacher called [the QP/L] and he took [staff #1] off the schedule for over a week ..." Interview on 11/18/22 with staff #1 revealed: -"On 11/2/22, [client #1] was on restriction from the previous day (11/1/22) due to an incident that occurred at school. He was supposed to wash the dishes but refused because he said he would not get his chore pay. I explained to him that he would get his chore pay but would not get points. He stated again he was not going to wash the dishes, so I told him to go to his room." -When client #1 went to his room, he started banging on the walls. -"I went in to check on him and to process with him to see why he was having these behaviors. I stood at the door and watched him. When I asked him why he was doing things, he picked up a white lamp and slung it at me. Then he picked up a heavier lamp. I grabbed this lamp from him and he started screaming. I grabbed a chair and sat and watched him. I sat in the doorway. He kept stomping his feet on the floor." -After a while, client #1 sat on the floor and pulled his covers and mattress on the floor and went to sleep. -When asked for clarification about the incident	V 367		

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V 367	Continued From page 25 with the heavier lamp, staff #2 stated "the only conflict we had was when I tried to grab the lamp from him. I grabbed the lamp with one hand and pushed [client #1] with my other hand. He fell on the bed. I pushed him under the arm pit area. I separate the lamp from him but not restrain him. It was not a big tussle. I just grabbed the lamp he was trying to throw at me and pushed him away from me." Interview on 11/17/22 with the QP/L revealed: -"[Client #1] made an allegation that [staff #1] held him down and that the staff had him by the neck. He made the allegation either on a Wednesday or Thursday. It may have been Wednesday as [staff #1] was scheduled to return to work on Thursday ...the police and a social worker came out to talk to [client #1] as he told the school staff he was not returning to the facility ...I learned about the allegation on 11/3/22 and I immediately took [staff #1] off the schedule for a week ... -Had completed a level I incident report -"I did not enter anything into IRIS. I just thought it was a level I incident and completed the internal investigation. Do I need to enter it into IRIS?	V 367		