STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601487	A. BUILDING: _____ B. WING _____	R 03/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSON COTTAGE-THOMPSON CHILD AND FAM	6700 SAINT PETERS LANE MATTHEWS, NC 28105

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 03/13/2023. The complaint (intake #NC00196461) was substantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1800 Intensive Residential Treatment for Children or Adolescents. This facility is licensed for 9 and currently has a census of 6. The survey sample consisted of audits of 2 current clients and 1 former client.	V 000		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure fire and disaster drills were conducted quarterly and repeated on each shift.	V 114		

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V 114	Continued From page 1 The findings are: Review on 02/22/2023 of the facility's fire and disaster drills log from 02/01/2022- 01/31/2023 revealed: -No documentation to support completion of 3rd shift (11pm-7am) fire and disaster drills for the 1st quarter from February 2022 - April 2022, 2nd quarter from May 2022 - July 2022, or 4th quarter from November 2022 - January 2023. Interview on 02/22/2023 with Client #1 revealed: -Admitted 2 weeks ago. -"I have not done one (fire or disaster drill) since I have been here." Interview on 02/22/2023 with the Team Lead revealed: -"Yes, we do drills during the overnight hours." -"I worked overnight in January 2023, and I did one then. We do them between 4 and 5 in the morning." Interview on 02/28/2023 with the Residential Supervisor/Qualified Professional revealed: -Maintenance Department was responsible for completing fire and disaster drills. Interview on 02/22/2023 with the Quality Improvement Specialist revealed: -Shifts were 1st (7a-3p), 2nd (3-11pm) and 3rd (11pm-7am). -Switched to 12 hours shift on February 1, 2023. Interview on 02/28/2023 with the Chief Facilities Officer revealed: -Was the head of the Maintenance Department and responsible for ensuring completion of fire and disaster drills. -"We have to have 1 while they are sleep. So, if	V 114		

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V 114	Continued From page 2 they were still in bed at the time, we would consider it part of 3rd shift."	V 114		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.	V 132		

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V 132	Continued From page 3	V 132		

This Rule is not met as evidenced by:
Based on records reviews and interviews, the facility failed to ensure that the Health Care Personnel Registry (HCPR) was notified of all allegations against health care personnel. The findings are:

Review on 01/19/2023 of the facility's record revealed:
-No documentation of notification to HCPR for Former Staff (FS) #3 placing a pillowcase over the head of Former Client (FC) #5 and Former Therapist placing a N95 face mask over the nose and mouth of FC #5 during a physical restraint dated 12/06/2022.

Interview on 02/28/2023 with the Residential Supervisor/Qualified Professional revealed:
-Was responsible for HCPR notifications.
-"I guess we just did not consider it abuse."
-Did not notify HCPR of incidents dated 12/06/2022 for FS #3 and Former Therapist.

Interview on 01/19/2023 with the Quality Improvement Specialist revealed:
-Was responsible for HCPR notifications.
-"12/06/2022 incident with [FS #3] placing a

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V 132	Continued From page 4 pillowcase over the head of [FC #5] did happen. Staff [FS #3] no longer work here. She was let go as a result of the incident." -Did not notify HCPR of incidents dated 12/06/2022 for FS #3 and Former Therapist. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 132		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal	V 366		

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V 366	Continued From page 5 regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The	V 366		

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V 366	Continued From page 6 final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement written policies governing their response to level I, II, and III incidents affecting 1 of 1 audited Former Clients (FC #5). The findings are:	V 366		

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V 366	Continued From page 7 Review on 01/19/2023 of the facility records revealed: -No Risk/Cause/Analysis or documentation to support submission of the written preliminary findings of fact to the Local Management Entity/Managed Care Organization (LME/MCO) within five working days for Former Staff (FS) #3 placing a pillowcase over the head of FC #5 and Former Therapist placing a N95 face mask over the nose and mouth of FC #5 during a physical restraint dated 12/06/2022. Interview on 02/28/2023 with the Residential Supervisor/Qualified Professional revealed: -Was responsible for but did not complete the Risk/Cause/Analysis or submit the written preliminary findings of fact to the LME/MCO within five working days for the incidents dated 12/06/2022. -Residential Director and Performance Quality Improvement Department were also responsible for completing the Risk/Cause/Analysis and submission of the written preliminary findings of fact for the incidents dated 12/06/2022. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within	V 367		

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V 367	Continued From page 8 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 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	V 367		

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V 367	Continued From page 9 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 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:	V 367		

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V 367	Continued From page 10 Based on record reviews and interviews, the facility failed to report all level II and III incidents in the Incident Response Improvement System (IRIS) and notify the Local Management Entity (LME)/Managed Care Organization (MCO) responsible for the catchment area where services were provided within 72 hours of becoming aware of the incident affecting 1 of 1 audited Former Clients (FC #5). The findings are: Review on 01/19/2023 of the facility records revealed: -No IRIS report submitted for Former Staff (FS) #3 placing a pillowcase over the head of FC #5 or Former Therapist placing a N95 face mask over the nose and mouth of FC #5 during a physical restraint dated 12/06/2022. -No documentation of LME/MCO notification. Review on 01/19/2023 of the IRIS from 12/06/2022-01/18/2023 revealed: -IRIS report submitted for a physical restraint involving FC #5 dated 12/06/2022 but no updates to the report after learning on 12/15/2022 that Former Staff (FS) #3 placed a pillowcase over the head of Former Client (FC) #5 and Former Therapist placed a N95 face mask over the nose and mouth of FC #5 during the physical restraint dated 12/06/2022. Interviews on 01/19/2023 and 02/28/2023 with the Residential Supervisor/Qualified Professional (QP) revealed: -Did not have knowledge of the pillowcase incident when the IRIS report was completed on 12/07/2022. -QIS informed him of the pillowcase incident on 12/15/2022. -Did not update the IRIS report with additional information or notify the LME/MCO within 72	V 367		

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V 367	Continued From page 11 hours of becoming aware aware of the pillowcase and face mask incidents dated 12/06/2022. Interview on 01/19/2023 the QIS revealed: -Was informed by Registered Nurse #2 that FS #3 placed a pillowcase over the head of FC #5 on 12/15/2022. -Conducted an internal investigation for the pillowcase incident. -Did not conduct an internal investigation for the face mask incident. -Did not update the IRIS report with additional information or notify the LME/MCO within 72 hours of becoming aware of the pillowcase and face mask incidents dated 12/06/2022. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 367		
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	V 537		

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V 537	Continued From page 12 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 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;	V 537		

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V 537	Continued From page 13 (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 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	V 537		

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V 537	Continued From page 14 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 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	V 537		

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V 537	Continued From page 15 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, interviews and observations, 2 of 2 Former Staff (FS) (FS#3 and Former Therapist) failed to demonstrate competency in restrictive interventions. The findings are: Review on 01/19/2023 of FC #5's record revealed: -Admitted 11/7/2022. -Age 14. -Diagnosed with Disruptive Mood Dysregulation Disorder (DMDD), Attention Deficit Hyperactivity Disorder (ADHD), and Anxiety Disorder. -Comprehensive Clinical Assessment (CCA) dated 06/22/2022; "Per the CSP (Crisis Stabilization Program) referral, the patient was referred to CSP due inability to manage the following symptoms: elopement from the group home, anger outbursts, physical aggressive towards both staff and peers, and threats to stab/kill others." Review on 01/23/2023 of FS #3's personnel record revealed: -Hired 04/18/2022. -Terminated 01/10/2023. -Job title Residential Care Specialist (RCS). -Therapeutic Crisis Intervention (TCI) Training; Initial 04/22/2022 Updates 6/17/2022 and 10/12/2022.	V 537		

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V 537	Continued From page 16 Review on 01/26/2023 of the Former Therapist's personnel record revealed: -Hired 08/15/2022. -Resigned 01/06/2023. -Job title Therapist. -TCI Training; Initial 12/09/2022. Review on 01/19/2023 of the facility's video surveillance for incident dated 12/06/2022 revealed: Williamson Cottage Foyer; -FC #5 on the floor in a seated restraint. Her back was against the wall. Her head was slumped down with Staff #1 holding her left arm and Staff #2 holding her right arm. Staff #1's leg was on top of FC #5's left leg and Staff #2's leg was on top of FC #5's right leg. -Registered Nurse (RN) #1 and Former Therapist stood in front of FC #5, Staff #1, and Staff #2 and observed. -Staff #1 and Staff #2 had on N95 face masks. -FC #5 struggled to get out of the restraint by moving and shaking. Staff #1 and Staff #2 continued to hold their grip on FC #5. -FC #5 moved her head back and forth and periodically looked in the direction of Staff #1. RN #1 exited the room. -Another resident entered the room aggressively but was stopped and escorted out by Former Therapist. -FC #5 continued to struggle. Former Therapist exited the room. -Former Therapist re-entered the room and placed a white N95 mask over the nose and mouth of FC #5. FC #5 continued to move and struggle as Former Therapist continued to attempt to place the N95 mask on her face. -FC #5 continued to move her head, which caused the mask to move off her nose and mouth.	V 537		

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V 537	Continued From page 17 -RN #1 re-entered the room. FS #3 entered the room with a pillowcase in her hand and stood at the door briefly, then walked over to FC #5 and placed the pillowcase over FC #5's head. RN #1 and Former Therapist observed. -FC #5 continued to move but shook her head more frantically. After approximately 5-10 seconds the pillowcase was removed. -Seated restraint of FC #5 continued. Review on 01/19/2023 of a document titled "Investigation Report" dated 12/16/2022 and completed by the Quality Improvement Specialist (QIS) revealed: -"RE: Incident involving staff placing pillowcase over [FC #5]'s head while she was spitting. -The Complaint/Allegations; Date: 12/06/2022. -Incident (s): QIS received an email from [Residential Supervisor/Qualified Professional (QP)]. 'On 12/6 I was informed by [Staff #1] that [FC #5] was put into a restraint. [Staff #1 and Staff #2] Initiated the restraint. On 1215 2022 I was informed that during the restraint [FC #5] was spitting on staff and staff member [FS #3] put a pillowcase over [FC #5]'s had to stop her from spitting.' -Conclusions: Based on the [Video Surveillance System], [FS #3] can be seen placing a pillowcase over [FC #5]'s head while she's in a restraint. -Date/Time the Investigation Was Completed: 12.21.22 6:30pm." Interview on 02/16/2023 with the Learning and Development Specialist/TCI Instructor revealed: -Reviewed video footage of the 12/06/2022 incident which involved FC #5. -" ... For that training (Initial TCI) there is a part that discuss the dos or don'ts and one of the things is to not place anything over the client's	V 537		

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face. Especially, the nose or mouth."
-Former Therapist was trained in TCI and knew not to place a mask over FC #5's face, nose, and mouth.
-"So, it was not appropriate for the staff (Former Therapist) to place the mask over the client's face."
-"Staff can get something to protect themselves; face shield, towel, or something like that to protect them from the spit. But nothing should be placed over the child's face, nose, or mouth."
-TCI trainings covered not placing anything over a client's face, nose, or mouth during a restraint.

Attempted interview on 01/26/2023 with FC #5 was unsuccessful due to refusal to answer any questions about the incident by stating, "I dont want to talk about it"

Attempted interview on 01/24/2023 with the Former Therapist was unsuccessful due to no response to phone call prior to survey exit date 02/28/2023.

Interview on 01/19/2023 with Staff #1 revealed:
-Initiated a restraint with FC #5 and Staff #2 on 12/06/2022.
-"[FC #5] spit in my face. She continued to spit in my face; there was a nurse and therapist there (when she was spitting in my face). So, [Staff #2] said can anybody switch out with me. [FS #3] came with a pillowcase and put it over her (FC #5) face and the nurse said, 'you cannot do that' and then she (FS #3) took it (pillowcase) off [FC #5]'s face. And then she swapped out with me."

Interview on 01/24/2023 with Staff #2 revealed:
-Initiated a restraint with FC #5 and Staff #1 on 12/06/2022.
-"She (FS #3) walked in and I saw something in

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V 537	Continued From page 19 her hand and then I heard the nurse say, 'you cannot do that' and when I looked at [FC #5], she had a pillowcase over her face. Her face was covered, but immediately when the nurse said, 'you cannot do that', she (FS #3) immediately removed the pillowcase. It (pillowcase) was probably on her face for a few seconds." Interview on 01/24/2023 with FS #3 revealed: -Was trained in TCI. -Was terminated on 01/10/2023 for reasons other than the 12/06/2022 pillowcase incident. -" ... restraint but not dealing with a spitter. They told us to turn our head. [Learning and Development Specialist], the training person said 'if a client is spitting to turn your head'." -"I only went to go get the sheet (pillowcase), because I was told to do so. The staff [Staff #1] asked me to go get a sheet ... So, I went to go get the sheet (pillowcase) and when I came back, they (Staff #1 and Staff #2) had her (FC #5) on the ground and they had a N95 mask on her face, but she was taking the mask off." -"She (FC #5) was moving around being combative and that's when [Staff #2] asked me to switch out. [Staff #2] could not handle [FC #5]. So, I draped the sheet (pillowcase) on the top of her head and then [Staff #1] pulled it over her head and that is when the nurse said, 'no, yall cannot do that'. Then I immediately took it (pillowcase) off her head and I literally said, 'I did not know that'." -"I came in early (at 11 am) on 12/15/2022 and I got a call from the supervisor [Residential Supervisor/QP] and was told to leave. He called me back before 3 pm and said that he needed me to leave, because of the incident with [FC #5]. He said, 'it was abuse' and I was like hold on that was not what I was trying to do. I was like okay; I am not understanding this at all."	V 537		

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V 537	Continued From page 20 -"The nurse (RN #1) saw everything, and she could have stopped it. I don't know why I am the only one in trouble. I was not the one that actually pulled it (pillowcase) down over her (FC #5) head. I was like I did not physically do it. I draped it and saw [Staff #1] pull the pillowcase over her head. I was not worried about being spit on and the only one that being attacked was [Staff #1]." Interview on 01/24/2023 with RN #1 revealed: -Was an RN. -Witnessed the 12/06/2022 incident which involved FC #5. -Reported the incident to RN #2. -Did not document the incident. -Did not report the incident to the Nursing Supervisor. -"I immediately told her (FS #3) 'no' that she could not do that. [FC #5] was spitting at all of them (Staff #1, Staff #2, and FS #3), and they were trying to prevent her from spitting. When I said you cannot do that, she (FS #3) said that is what she did the last time." -"They (staff) are not well educated on restraints at all. I have made it very clear to the lady (did not remember the name of the person) that called me about it when it happened, and I made it very clear that staff is not educated correctly about what they can and cannot do. Sometimes they don't know how to do restraints." -"To be honest, because I told her (FS #3) to take it (pillowcase) off and she did. I did not think it was an incident. I know the staff (FS #3) did not mean any harm by it, but because the pillowcase was not on there for long, I did not think to write it up." -"At that time, I did not have access to the nursing side of [Licensee's computerized data base], so I would not have been able to write it."	V 537		

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V 537	Continued From page 21 Interview on 02/16/2023 with the RN #2 revealed: -Was an RN. -Watched the 12/06/2022 incident on camera in real time. -" ... [RN #1] went down and I pulled the camera up and I saw they were in the hall way and I saw something on her head and I could not figure out what it was it. I saw an item, but I did not know what it was on her (FC #5) head and [RN #1] said it was a pillowcase. [RN #1] told them to remove it and they removed it straight away.". -"I just see that she (RN #1) filed out an RI (Restrictive Intervention); her part in the restrictive intervention. There is not a nursing note specific to the incident in general. Put it this way, I always do a nursing note after an intervention. I can't answer if there legally should be a nursing note." Interviews on 01/19/2023 and 02/28/2023 with the Residential Supervisor/QP revealed: -Found out about the pillowcase incident from the QIS on 12/15/2022. -Staff #1, Staff #2, RN #1 and Former Therapist witnessed the pillowcase incident but did not report the incident. -"I had a staff meeting with all the staff on 12/20/2022. We went over proper restraint protocols and de-escalation and I told them that 'you cannot put a pillowcase over anyone's head'." -"I am not sure if it (staff meeting agenda) specifically said 'pillowcase'." Interview on 01/19/2023 with the QIS revealed: -Learned about the pillowcase incident from RN #2 on 12/15/2022. -"12/06/2022 incident with [FS #3] placing a pillowcase over the head of [FC #5] did happen.	V 537		

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V 537	Continued From page 22 Staff [FS #3] no longer work here. She was let go as a result of the incident." Review on 02/27/2023 of the Plan of Protection (POP) dated 02/27/2023 and signed by the QIS revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? 1. Program Supervisor will conduct another training with Residential Care Specialists on RI's (Restrictive Interventions) to include the use of masks, hoods, etc. not being placed on clients' heads, noses or mouths during a restraint. Program Supervisor will thoroughly document the training. The training will take place on 2/28/23 during the staff meeting. 2. Nurse Supervisor will ensure Nursing staff will be re-trained on the abuse and neglect policy as well as the incident report process via email communication on 2/27/23. Read receipts will be requested in this communication. 3. Nurse Supervisor will also address this at the next staff meeting, by 3/10/23. Describe your plans to make sure the above happens. Program Director will attend the staff meeting tomorrow, 2/28/23, to ensure staff training occurs and documentation of meeting will be submitted to PQI (Performance Quality Improvement) by the end of the week, 3/3/23. Nurse Supervisor will copy PQI on email communication and submit staff meeting documentation to PQI by 3/10/23." FC #5 was a 14-year-old female diagnosed with DMDD, ADHD, and Anxiety Disorder. Her risk history includes anger outbursts, physical aggressive towards both staff and peers, and threats to harm others. FC #5 was placed in a physical restraint by Staff #1 and Staff #2 on 12/06/2022. Former Therapist and FS #3 received evidenced based intervention training.	V 537		

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V 537	Continued From page 23 FC #5 was spitting at staff during the restraint. The Former Therapist placed a N95 mask over FC #5's nose and mouth. When FC #5 managed to free herself of the mask, FS #3 placed a pillowcase over FC#5's head. Both FS#3 and Former Therapist had been trained in TCI protocol to never place anything over the face, nose, or mouth of a client during a physical restraint.This deficiency constitutes a Type A1 rule violation for serious abuse and neglect and must be corrected within 23 days. An administrative penalty of $3000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 537		