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	MHL036-347	A. BUILDING: ______ B. WING ______	R **03/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE	**600 BETTY STREET GASTONIA, NC 28054**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 3/2/23. The complaints were substantiated (intakes #NC00197293, #NC00197826, #NC00197856). 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 3 and currently has a census of 3. 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;	V 110		

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(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 interviews, observations and record reviews 2 of 7 staff (staff #1, #7) failed to demonstrate the knowledge, skills, and abilities required by the population served. The findings are:

Findings #1:

Review on 2/1/23 of staff #7's record revealed:
- Hire date 10/26/22
- Job Title: Direct Support Professional

Review on 2/6/23 of audio of staff #7 talking to client #1, #2, #3 on 1/25/23 revealed:
- Staff #6 recorded 50 minutes of audio between staff #7 and client #1, #2 and #3;
- Staff #7 yelling at clients ..."girl shut up, go in your room, stay out of it, it don't have anything to do with you, go in your room, go in your room, you haven't been here but for 2-3 weeks, go in your room (clapping his hands and stating) bye, I'm tired of looking at you, I'm tired of looking at your face, bye, I don't want to see you";
- Clients are heard mumbling something in the

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about being in each others personal space;
- Staff #7 stated that a client was "right now your pointing your hands at me and I feel threatened by it, I feel threaten, I feel threaten with your hands, I feel feel threaten you could possibly reach out and hit me, please put your hands down, it don't matter, it don't matter, ooh, is that the police.";
- Heard clients make comments "I hope so, no, ain't no police, I hope so."
- Staff #7 stated "well they going to take you, they taking you.";
- Heard clients make comments "they going to take us, they going to take us to a little place, I don't want to stay here.";
- Staff #7 told clients "Well if you don't want to stay here, leave the door is opened, walk walk, I said go head, the hospital will find you, go you can stay at the hospital for a couple of days.";
- Heard clients state "I'm good.";
- Heard clients and staff start to cheer and clap hands because they hear sirens.
- Staff #7 stated "I'm so happy."
- Heard a client say "yeah because he said somebody tried to cut his throat open, ain't nobody hurt bruh."
- Staff #7 stated "this is good, this is good, I don't know where y'all going because y'all are not allowed outside, until the police come in here. when the police come in here to speak to y'all, the police can can come in here and speak to y'all, until they wanna come in here and speak y'all are not allowed outside. It's that simple, Ok, when they get out here I will let you know but you won't be coming out."
-Staff # 7 then stated "what are you going to do, move me, you going to move me.";
- Clients were heard talking in the back ground "so don't say nothing, I have nothing to say no more, open the window." (unclear exactly what is

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V 110	Continued From page 2 background; - Staff #7 stated "thank you, have you looked at yourself in the mirror, have you looked at yourself in the mirror."; - Heard a client state "I know I'm beautiful, you mad, you mad."; - Staff #7 asked staff #6 "you ok, do they act like this all the time."; -Staff #6 stated "they good kids, they really is, I don't, yeah, to me they is, I don't, I don't know what is going on, I'm trying to stay out of it, I don't know what is going on."; - Staff #7 stated "this is crazy."; - A client made a comment about staff not knowing when to shut up; - Staff #7 stated "Oh I don't."; - A client is heard stating "clearly."; - Staff #7 stated "I don't."; - A client is heard stating "that's why you are going to get in trouble for it."; - Staff # 7 asked "girl howma get in trouble, howma get in trouble you hit me."; - A client is heard stating "you'll find out."; - Staff #7 stated "you hit me, [client #3] hit me; - Heard a client say "I hit you."; - Staff #7 stated "[client #3] hit me, [client #3] did hit me, [client #3] hands went on me."; - Heard a client say "but then you said I hit you."; - Staff #7 stated "It don't matter [client #3] hands were on me."; - Heard a client say "no one hit you bruh."; - Heard staff #7 and clients go back and forth about who hit who, (some of the comments were unclear due to everyone talking at the same time); - Staff #7 stated "girl no it wasn't hush, I'm tired of talking to you."; - Staff #7 told clients "figure out what you want to be in life then talk to me."; - Heard staff #7 and clients go back and forth	V 110		

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being said by the clients)
- Staff #7 "So now you going to jump out the window, oh I love this, I love that you are jumping out the window, great let me call and report this.";
- Clients are heard making comments while staff #7 is talking "no one said they were jumping out the window, you are a F*****g loser, what the F**k, go ahead keep lying, you're lying keep lying, you're lying."
- Staff #7 stated "[Client #3] it don't have anything to do with you, shut up, like lord shut up, you always butting into something that don't have anything to do with you, like I don't care, shut up you run your mouth too much, no, if you shut up then I will shut up, if you shut up I will shut up, shut up if [client #1] shut up then I will shut up, like shut up, like dang, you run your mouth too much, shut up.";
- Heard a client state "you said the most", then staff stated "no you said the most, you put your hands on me.";
- Heard a client state "look at him rethinking his bad decisions.";
- Staff #7 stated "I'm not rethinking anything, I don't have any bad decisions, oh let me erase this.";
- A client stated "he just called me a racist.";
- Staff #7 stated "you are racist.";
- Clients were talking about the incident to themselves;
- Staff #7 stated "Thanks for putting your hands on me though.";
- Heard a client state "no problem, go ahead and keep lying, thanks for lying.";
- Staff #7 replied "you welcome.";
- Heard a client state "he said you welcome because he knows he is lying." (other comments were being made but unclear to everything being said);
- Staff #7 stated "You did put your hands on me,

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V 110	Continued From page 5 So you didn't put your hands on me [client #3], so you didn't put your hands on me [client #3]."; - Client stated "I did not."; - Staff #7 "oh wow you are a liar, you did, your hands hit me." - Heard a client asked about where is the bruise; - Staff #7 stated "just because there are no bruises don't mean you didn't touch me."; - Heard a client state "he didn't touch you for real , he touched my shoulder while you tried to grab the phone, and you was in my personal space."; - Staff #7 replied "no I was not, the phone is the company's, the phone is the company's."; - A client stated "but you were in my personal space."; - Staff #7 then stated "[Client #1] why are you talking to me, why are you talking to me."; - A client replied "why are you speaking in general, don't no one want to hear your mouth, it's kinda aggravating." - Staff #7 stated "why are you talking to me (repeated this 5 times), like why are you talking to me."; - Clients were calling staff #7 a loser, and making comments (unclear exactly what they were saying) - Staff #7 stated "y'all know y'all don't put no fear in my heart." - The audio was a little hard to understand as staff #7 and clients discussed fear and threatening of each other; - A client stated "you can't hurt none of us."; - Staff #7 stated "I know that but you can't hurt me either." - A client stated that she was leaving the room to change clothes, the sound of a door opens and staff #7 goes outside, you can hear him from a distance talking as if he is on the phone talking with someone. Things calm down in the home for a moment, the clients are in the home making	V 110		

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comments about you can look at camera to see what happened, clients are talking about being taken away in hand cuffs, singing songs with cuss words and vulgar language, discussing the incident that just happened with staff #7;
- Heard all of the clients make comments about going to jail "I'm not fend to be here tonight, [client #3] you going to jail, apparently, apparently all of us, He said you too [client #2], I'm not going to jail.";
- Staff #6 then replied "h**l they minus well take me too."'
- A client replied "right, right, you heard that, you going to stand for us, you going to stand for us."
- Whispering takes place (staff #6 and clients);
- Staff #6 stated "don't say nothing, don't let him know I'm recording him.";
- Music is heard playing and clients talking;
- A client stated "oh there he is, he back.";
- Staff #7 comes back into the home while clients are listening to music with profanity and vulgar language;
- Staff #7 stated "I need this off, I need this song off, so now y'all threatening to shoot me.";
- Staff #7 stated "So now y'all are threatening to shoot me."
- Heard clients and staff go back and forth debating the lyrics of the song, clients continued to listen to the song, then another song came on;
- Staff #7 stated "wow, so now y'all want to fight."
- Music continues to play with profanity and vulgar language as clients sing along;
- Staff #7 asked "can y'all turn that off, can y'all turn that off.";
- A client stated "what";
- Staff replied "can y'all turn that off.";
- A client replied "no because you were steady trying to say some s**t we didn't do.";
- Staff #7 stated "ok so now I'm going to have to call the police, now I'm calling the police.";

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V 110	Continued From page 7 - Client replied "you wanna call the police now."; - Staff #7 "I'm calling the police."; - Client replied "You didn't ask."; - Staff #7 "I'm calling the police."; - A client replied "you didn't ask."; - Staff #7 stated "I'm calling the police."; - A client replied "you didn't ask."; - Staff #7 stated "turn the music off or I'm calling the police."; - A client replied "you didn't ask, call them, you didn't ask, so why we going to."; - Staff #7 stated "I don't want to talk to you, why you talking to me, turn the music off, ok I'm calling the cops."; - Clients continued to listen to music, then started to inquire about dinner; - Staff #7 asked Staff #6 "you cooking dinner?"; - Staff #6 replied "oh yeah I can."; - Staff #7 stated "ok."; - Heard a client stated "now they want to do something, now he want to say something."; - Staff #7 replied "I'm not making it, so I don't care." - Staff #7 told Staff #6 "you can go ahead and make it."; - Heard a client state "yeah, exactly because this lazy a*s bum don't want to make s**t."; - Staff #7 replied "Oh you said I'm what."; - A client stated "a lazy bum."; - Staff #7 replied "I'm a what."; - A client replied "a lazy bum."; - Staff #7 replied "I'm a lazy what."; - A client replied "a lazy bum, cause you didn't want to cook us dinner."; - Staff stated "so now I'm a lazy bum, awww."; - Heard a client say "cause you didn't want to cook us dinner."; - Staff #7 replied "aww, aww but you're here."; - A client stated "now you want to act innocent."; - Staff #7 continued to state "but you are here, but	V 110		

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V 110	Continued From page 8 you are here, but I'm a bum, Next, [client #3] I'm not talking to you, why are you talking to me."; - Clients then continued to play music with vulgar language and profanity as they sung the lyrics; - Staff #7 started yelling "come on cops, (repeated 6 times)."; - A client is heard saying "man shut your scary a*s up, that's why you..." unable to hear the last word client says due to staff #7 started to yell "come on cops, come on cops, I'm scary, I'm scary."; - Clients continue to play music with profanity and vulgar language as they sung the lyrics; - While the song was playing Staff #7 sung one of the lyrics "I don't give a F**k tomorrow." - Staff #7 stated "I'm hood, I'm ghetto, whoo, whoo whoo."; - Clients continue to listen to music and sings the lyrics; - Staff #7 stated "they coming."; - Staff #7 stated "oh now everybody scared because the cops are about to be here."; - Heard a client say "ain't nobody scared."; - Staff #7 replied "now y'all scared oh you scared, y'all scared the cops are coming, oh y'all scared, oh girl you scared, all that mouth but scared, you scared, you scared, you scared, you really scared ..." - Heard clients state "we're waiting." (other comments were made but they were unclear, as clients were talking at the same time staff #7 was talking); - Staff #7 stated "Lets see what crazy meds (medications) you take."; - A client replied "you hear that."; - Staff #7 stated "D**n"; - Staff #7 stated "D**n 4 pills."; - Client stated "he says I'm crazy, I know my meds." (clients are making comments about their medications but the comments are unclear)	V 110		

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- Clients continued to listen to music with profanity and vulgar language while singing the lyrics ....
-Heard a client mention the ambulance and the door opened, clients were heard making comments about Staff #7 outside acting like he is hurt. Clients continued to make comments about staff #7 lying and acting like he was hurt. A police officer came to the door and asked who was all in the home. the clients informed her it was only 3 clients and 1 staff in the home. The clients asked the officer if they could come outside and speak with her. You then hear staff #7 come back into the home and talk with staff #6 and talk on the telephone. The audio ends.

Interview on 1/26/23 with client #1 revealed:
- Staff #7 stated "you wouldn't be here if your parents actually loved you.";
- Staff #7 "got up in our faces and was yelling at us.";
- Staff #7 stated "I wish y'all all would go AWOL(absent without leave), no one is going to call the cops.";
- Staff #7 stated he was afraid of the clients because they are on medication;
- Asked staff #6 to call someone to come to the home to de-escalate the situation;
- Staff #7 asked if client #1 was going to hit him;
- Went inside of the kitchen with the telephone to make a call;
- Staff #7 reached over client #1 to take the phone;
- Client #3 reached over client #1's shoulder to block staff #7 from taking the telephone from client #1;
- Staff #7 stated client #3 hit him when he pulled his hand back from grabbing the telephone from client #1 and his hand rubbed against client #3's

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hand;
- Staff #7 called the police to the home;
- Staff #7 pretended his hand was hurt when the police arrived at the home;
- Staff #7 hit and scratched his hand, so that he would have marks on his hand;
- The police and two ambulances came to the home;
- Staff #7 was checked by the Emergency Medical Services (EMS);
- Staff #7 left the group home during shift after the police and EMS left the home.

Interview on 1/26/23 with client #2 revealed:
- Staff #7 argued with client #1 and #2;
- Client #1 attempted to call her social worker or the crisis line due to arguing between staff #7 and clients;
- Client #1 got the phone and handed it to staff #7;
- Staff #7 looked at client #1 with the phone and turned around and continued to argue with client #3;
- Staff #7 told client #1, #2 and #3 to go AWOL, no one would call the police.;
- Staff #7 attempted to grab the phone out of client #1's hand;
- Staff #7 stated client #3 "purposely" hit him when he was trying to get the phone from client #1;
- Staff #7 stated he was calling the police to press charges on client #3;
- Staff #7 went outside and "faked calling the police for about 4 minutes", stating "these kids are trying to slit my throat."
- The police came and talked with everyone;
- Staff #7 walked off the job when the police left.

Interview on 1/26/23 with client #3 revealed:
- Staff #7 was very disrespectful, "he came in the

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kitchen clapping his hands" while arguing with client #1, #2 and #3;
- "I gently blocked his(staff #7) hand from grabbing the phone from client #1.";
- Staff #7 started yelling for client #1, #2 and #3 to go AWOL, " no one is going to care.";
- Staff #7 called the house manager and was instructed to take "our points";
- Staff #7 told client #1, #2 and #3 "y'all going to jail, and I'm going home to sleep peacefully, while y'all going to be in orange suits.";
- Staff #7 pretended to call the police and state "we threaten to cut his throat.";
- Clients turned on music and started being "ratchet"
- Staff #7 made comments to clients, "that's why you are in a group home and no one love you."
- The police came to the home;
- Client #1, #2 and #3 talked with the police;
- Staff #6 air dropped the audio she recorded of staff #7's behavior to the police;
- Staff #7 left the group home.

Interview on 2/1/23 with staff #7 revealed:
- Warned upon arrival to the group home the clients were a little aggressive already;
- Client #3 started cussing due to not wanting to participate in the therapeutic activity;
- Talked with client #3 about her actions;
- Client #1 then interrupted the conversation between staff #7 and client #3;
- Attempted to redirect client #1;
- The clients then turned on "inappropriate music", "I turned off the music"due to the lyrics;
- Clients continued to be argumentative;
- Client #1 snatched the telephone up;
- "[Client #3] grabbed my arm really tight", when trying to get the phone from client #1;
- The police came to the home and spoke with everyone that was in the home;

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- Administered medication to the clients;
- Left the group home;
- Staff #6 did not provide any assistance to staff #7 to de-escalate the situation
- "The clients made comments to me stating that I was crazy and my response to them was that I'm not the one taking any meds."
- Never told clients that their parents don't love them.

Interview on 2/9/23 with the Licensee/Qualified Professional #2 revealed:
- Staff #7 was "inappropriate with comments to clients.";
- Staff #7 "antagonized" clients during incident on 1/25/23;
- Planned to meet with staff #7 to discuss inappropriate behaviors, trainings and write up.

Findings #2:
Review on 1/25/23 of staff #1's record revealed:
- Hire date 12/10/22;
- Job title: Direct Support Professional

Review on 1/25/23 of the facility's Internal Investigation Report dated 1/3/23 revealed:
- Report was investigated by the Group Home Manager;
- Client #2, #3 and Former Client (FC#4) were interviewed;
- Staff #1 was interviewed;
- Identify disciplinary actions taken: "Clients were placed on off-trust for major manipulation and the staff member (staff #1) is unable to work hours at the [facility] location following the investigation."
-Investigation Summary: "The Group Home Manager, held a meeting with [staff #1] due to allegations of her allowing clients to smoke marijuana on 1/1/23. [Client #2, #3 and FC #4]

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reported the allegations. In the meeting [staff #1] stated that the clients asked multiple times if she could purchase marijuana for them. [Staff #1] stated she was taken back when the clients asked this as it was completely inappropriate. [FC #4] told [staff #1] that [staff #3] let them smoke previously to manipulate the situation. There were allegations of [staff #3] allowing the clients to smoke marijuana approximately two weeks prior to this allegation. These allegations were unsubstantiated due to [FC #4] admitting to staff that she lied and proceeded to apologize to the staff member [staff #3]. [Staff #1] stated that she denied their requests for marijuana throughout the shift. [Staff #1] informed us that all of the clients asked the neighbor if they had any marijuana when they went walking, but staff redirected immediately. When [FC #4 and client #2] were talked to they all stated that [staff #1] had a friend in a red hat meet them at the store on the same street as the facility to purchase marijuana. They stated that they all smoked it (marijuana) behind the store and returned to the facility. The clients stories were consistent with each other. [Client #3] denied speaking on the allegations with staff when they held the interview, but later stated that the staff member did do so. Clients [FC#4, client #3 and #2] were drug tested on Tuesday January 3rd 2023. Immediately following management being made aware of the allegations, the clients were checked out of school, drug tested, and brought back to school. All test (drug screen) were negative for THC."
- Summarize the Investigation findings: "All clients are negative for THC and were unable to maintain the collected story."

Interview on 1/24/23 and 1/26/23 with client #2 revealed:
- Client #2, #3 and FC #4 were talking about

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V 110	Continued From page 14 vaping on 1/1/23; - Staff #1 gave permission to purchase a vape from a neighbor; - Staff #1 told clients #2, #3 and FC#4 to ask the neighbor about purchasing marijuana; - Staff #1 offered to contact her "drug dealer"; - staff #1 drove client #2, #3 and FC #4 to the local park to purchase the marijuana; - Staff #1 placed the marijuana in her bra; - Staff #1 walked with clients #2, #3 and FC #4 up the street from the group home, behind a building to smoke the marijuana; - "We were drug screened." - Drug screen came back negative - "They got the test from dollar tree." - "They wrote up something and it stated we were all making up allegations on staff." Interview on 1/24/23 with client #3 revealed: - Staff #1 allowed Client #2, #3 and FC #4 to ask a neighbor for a vape; - Staff #1 informed the clients that she would not say anything about the vape; - Staff #1 offered to pay the neighbor 5 dollars for marijuana for client #2, #3 and FC #4; - Staff #1 informed the clients she had someone she can purchase the marijuana from; - Staff #1 drove client #2, #3 and FC #4 to local park to purchase the marijuana; - Staff #1 paid the guy for the marijuana; - Staff #1 drove up the street and went behind a building to smoke the marijuana; - Staff #1 emptied out a cigar, put the marijuana in the cigar and rolled it for "us" to smoke; - "We all smoked it until the end." - Staff gave "us" a drug screen; - "I put water in my test and it came back negative, I'm not sure about what the others did." Interview on 2/7/23 with Former Client #4	V 110		

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revealed:
- Staff #1 gave client #2, #3 and FC #4 marijuana and they smoked it with her;
- Client #2, #3 and FC #4 was given a vape from a neighbor;
- Staff #1 asked client #2, #3 and FC #4 to ask neighbor about marijuana;
- Neighbor denied having any marijuana;
- Staff #1 called a guy she knew to purchase marijuana;
- Staff #1 drove client #2, #3 and FC #4 to the park to purchase the marijuana;
- Went behind the store with client #2, #3 and staff #1 to smoke the marijuana;
- "Felt weird" after smoking the marijuana;
- "They gave us a drug test, but it came back negative."

Interview on 1/30/23 with staff #1 revealed:
- Worked alone with client #2, #3 and FC #4 on 1/1/23;
- Client #2, #3 and FC #4 asked about marijuana while walking up the street with staff #1;
- "I don't know what made them ask that."
- "The whole situation has been messed up."
- "I have been cutting it (thoughts about the incident) off because it's not true, and I try not to think about it."
- "I have a son and I'm not trying to lose my child."

Interview on 2/1/23 with former staff #8 revealed:
- Completed an investigation about the incident on 1/1/23 with staff #1 and client #2, #3 and FC #4;
- Used personal time to follow through on all of the details client #2, #3 and FC #4 provided about the incident on 1/1/23;
- Client #2, #3 and FC #4 asked the neighbor for a vape and he gave them a vape;
- Staff #1 took client #2, #3 and FC #4 to the park

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to purchase the marijuana;
- Staff #1 and client #2, #3 and FC #4 drove back home and walked up the street to smoke the marijuana;
- Staff #1 and client #2, #3 and FC #4 went behind an old loading dock with a big dumpster and smoked the marijuana;
- Staff #1 sprayed everyone down with Lysol when they were done smoking the marijuana;
- FC #4 was really high and acting out of it;
- Informed the Licensee/Qualified Professional #2 of the information gathered and nothing was done, "they just keep sweeping it under the rug.";
- Licensee/Qualified Professional #2 stated that the "girls" make accusations all the time.

Interview on 2/3/23 with client #2's therapist revealed:
- Concerned client #2 had access to substances while at group home;
- There were two occasions when client #2 had a vape while in the group home;
- Client #2 informed her that she had marijuana then client #2 recanted her story;
- Client #2 stated that staff #1 took them to the corner store to smoke the marijuana;
- The next week client #2 stated they smoked the marijuana in the neighborhood;
- "When I confronted her about the changes in her story, she (client #20 then stated that it didn't happen.";
- "I can say with confidence, they (client #2, #3 and FC #4) intentionally wanted to get that staff member fired because she was stern with them."

Interview on 1/27/23 and 2/9/23 with the Licensee/Qualified Professional #2 revealed:
- Staff #1 denied the allegations of smoking marijuana with client #2, #3 and FC #4;

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- There was no training for staff #1 due to allegations of staff #1 smoking marijuana with the client #2, #3 And FC #4;
- Staff #1 was not drug screened due to allegations of smoking marijuana with clients;
- Staff #1 was no longer allowed to work at facility after the incident on 1/1/23.

Review on 2/9/23 of the Plan of Protection dated 2/9/23 written by the Director revealed:

"What immediate action will the facility take to ensure the safety of the consumers in your care?
[Staff #7] will be retrained in NCI(Nonviolent Crisis Intervention) training as well as verbal de-escalation training on 2/16/2023 to properly teach staff how to communicate with clients when they are in crisis.

[Staff #7] will receive a written disciplinary action to maintain in his file. A meeting will be held with [Staff#7] on 2/10/2023 to address the audio.

[Staff #1] has been terminated from [Licensee agency] effective 1/30/23 due to the allegations made against her regarding substance abuse.

Describe your plans to make sure the above happens.
[Director] will participate in meeting with [Staff #7] on 2/10/2023. [Director] will participate in verbal de-escalation training and document the attendees. [Director] will set up NCI training for [Staff #7] on 02/10/2023."

The facility served clients with Post Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder and Major Depressive Disorder. On 1/25/23 Staff #7 yelled and argued back and forth

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V 110	Continued From page 18 with client #1, #2 and #3. Staff #7 used profanity in front of the clients. At times when things were a little calm, Staff #7 would make a comment to the clients and things would escalate all over again. Staff #7 was unable to display appropriate decision making skills as he continued to engage in arguments with clients instead of attempting to de- escalate the situation. After hours of this behavior, Staff #7 left the home without a replacement in place on his shift. On 1/1/23, Staff #1 allowed client #2, #3 and FC #4 to interact with a neighbor and obtain a vape. staff #1 contacted a drug dealer and met him in a local park to purchase marijuana for the clients. Staff #1 and client #2, #3 and FC #4 walked up the street from the group home and smoked the marijuana. Staff #1 showed she was unable to make good decisions by purchasing an illegal substance and allowing the clients to use illegal substances. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 110		
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	V 293		

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V 293	Continued From page 19 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; (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.	V 293		

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V 293	Continued From page 20 This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to coordinate with other individuals and agencies within the adolescent's system of care for 1 of 3 clients(#2).The findings are: Review on 1/25/23 of client #2's record revealed: - Admission date 11/4/22; - Age 14; - Diagnoses: Post Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder - Discharge date 1/26/23. Interview on 1/26/23 with the Department of Social Services, Permanency Planning Social Worker revealed: - Learned on 1/17/23 about an incident that happened on 1/1/23 with client #2 but never received an incident report; - The Qualified Professional #1 was unable to provide the whereabouts of client #2 in the Child and Family Team Meeting on 1/26/23; - The Department of Social Services would be filing a grievance against the group home due to lack of communication. Interview on 2/1/23 with the Qualified Professional #1 revealed: - Sent emails to the teams(treatment team) when an incident occurred at the group home; - "It was my understanding that the teams were made aware of the marijuana incident on 1/1/23, but not all of them were." Interview on 2/9/23 with the Licensee/Qualified Professional #2 revealed:	V 293		

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V 293	Continued From page 21 - Emails were sent to the teams(treatment teams) when an incident occurred in the group home; - Had emails for proof of the coordination, that would be provided ; - As of exit, emails were not provided. This deficiency was cited 2 time(s) on 5/20/21, 5/23/22.	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 (3) three direct care staff shall be present	V 296		

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V 296	Continued From page 22 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 record reviews and interviews the facility failed to ensure minimum staffing ratio of two staff for up to four adolescents. The findings are: Review on 1/25/23 of client #1's record revealed: - Admission date 1/14/23; - Age 14; - Diagnosis: Post Traumatic Stress Disorder; - Behavior history: physical fights with peers. Review on 1/25/23 of client #2's record revealed: - Admission date 11/4/22; - Age 14; - Diagnoses: Post Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder; - Behavior history: eloping, suicidal ideation, aggression towards propety and engaging in risky	V 296		

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behaviors.

Review on 1/25/23 of client #3's record revealed:
- Admission date 1/24/22;
- Age 17;
- Diagnoses: Post Traumatic Stress Disorder, Major Depressive Disorder;
- Behavior history: Self harm, suicidal ideations, impulsive behaviors, rebellious/defiant behaviors and social withdrawal.

Review on 1/25/23 of the Incident Response Improvement System (IRIS) revealed:
- Client #2 was hit on the shoulder during an altercation on 12/31/22;
- Client #2 went to the local hospital and was given ice for bruised shoulder;
- Former Client (FC#4) was hit by a shoe from another client on 12/31/22;
- FC #4 went to the local hospital and was given an antibiotic due to slight damage inside of her eye.

Interview on 1/24/23 with client #1 revealed:
- There was only one staff that worked 3rd shift;
- One staff worked alone at least twice a week during 2nd shift;

Interview on 1/24/23 with client #2 revealed:
- One staff worked third shift;
- One staff worked alone once or twice a week during 2nd shift;
- Former Staff #8 worked alone on New Year's Eve with three clients;
- Went to sister facility on New Year's Eve because it was only one staff;
- Two clients got into a fight while at sister facility on New Year's Eve;
- Shoulder was hurt while other clients were fighting and had to go to the hospital;

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- Staff #1 worked alone on New Year's Day with three clients

Interview on 1/24/23 with client #3 revealed:
- One staff worked third shift;
- Had to go to sister facility on New Year's Eve "because there wasn't enough staff."
- While at the other home two girls got into a fight;
- Client #2 and FC #4 had to go to the hospital due to the fight;
- Staff #1 worked alone on New Year's Day with three clients.

Interview on 2/3/23 with Former Client (FC#4) revealed:
- New Year's Eve, Former Staff (FS#8) worked alone with 3 clients;
- FS#8 went to sister facility with client #2, #3 and FC #4;
- FC #4 got into a fight with another client at the sister facility;
- Had to go to the hospital due to being hit in the eye by a client in the sister facility;
- New Year's Day, staff #1 worked alone with client #2, #3 and FC #4.

Interview on 1/30/23 with staff #1 revealed:
- Worked alone with clients on New Year's Day with client #2, #3 and FC#4.

Interview on 2/1/23 with Former Staff #8 revealed:
- Worked alone with client #2, #3 and FC #4 on New Year's Eve;
- Was given permission from the House Manager and the Licensee/Qualified Professional #2 to blend the two group homes on New Year's Eve;
- While at the sister facility (licensed 1700 program) two clients got into a fight;
- Client #2 and FC #4 were taken to the hospital.

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	MHL036-347	A. BUILDING: ______ B. WING ______	R 03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE	**600 BETTY STREET GASTONIA, NC 28054**

(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
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Interview on 1/27/23 and 2/9/23 with the Licensee/Qualified Professional revealed:
- Permission was not given to FS #8 to transport client #2, #3 and FC #4 to sister facility;
- Two staff are scheduled to work 3rd shift every night;
- Hired more people to "help staff".

This deficiency was cited 2 time(s) on 5/20/21, 5/23/22.

Review on 2/9/23 of the Plan of Protection dated 2/9/23 written by the Director revealed:

"What immediate action will the facility take to ensure the safety of the consumers in your care?
[Director] has hired four Direct support Professionals to ensure there are always two people on each shift. They are currently finishing training as of 02/08/2023.

In the event that there is a call out, there are management and team leads that are able to get to the facilities within 30 minutes per policy.

[Licensee] held a staff meeting on 1/21/2023 to reiterate chain of command so that staff know who to contact on the event there are any issues.

[Licensee] staff have been reinformed that they are not allowed to combine houses for any reason by [Director] on 01/21/2023. Any staff who fails to comply will result in immediate termination.

[Director] will continue to fill in at facility when there are staffing needs.

Describe you plans to make sure the above

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V 296	Continued From page 26	V 296		

happens.

Daily check on Homebase system(electronic application used to record staff clocking in and out for shift) to ensure there are two people clocking in at all times. Pop ups at the facility to ensure that staffing requirements are continuously met. Monthly staff meetings to address any issues."

This facility served clients ranging in ages of 14-17 with Post Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder and Major Depressive Disorder. The clients had a histories of behaviors in eloping, suicidal ideation, physical aggression, impulsive behaviors and rebellious/defiant behaviors. Third shift staff routinely worked alone in the home. Second shift staff worked alone 1-2 times a week. On New Year's Eve, FS #8 was working alone and was given permission to transport client #2, #3 and FC #4 to the sister facility. While at the sister facility clients got into a fight and client #2 and FC #4 were taken to the hospital. client #2 had a bruised shoulder. FC#4 was given an antibiotic for slight damage inside of her eye. On New Year's Day Staff #1 worked alone with client #2, #3 and FC #4. 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 is imposed. If the violation is not corrected with 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 366 — 27G .0603 Incident Response Requirments — V 366

10A NCAC 27G .0603 INCIDENT

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V 366	Continued From page 27 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 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:	V 366		

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V 366	Continued From page 28 (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 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	V 366		

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V 366	Continued From page 29 (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 2 of 3 current clients (#2, #3) and Former Client (FC#4). The findings are: Review on 1/24/23 of Incident Response Improvement System (IRIS) from 10/24/22-1/24/23 revealed: -No IRIS report, Risk Cause/Analysis, or documentation to support submission of the written preliminary findings of fact to the Local Management Entity (LME)/ Managed Care Organization (MCO) within 5 working days for Staff #1 purchasing and smoking marijuana with client #2, #4 and FC # 4 on 1/1/23. - No IRIS report, Risk Cause/Analysis, or documentation to support submission of the	V 366		

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V 366	Continued From page 30 written preliminary findings of fact to the LME/MCO within 5 working days for Staff #3 allowing FC #4 to smoke marijuana on approximately 12/18/22. Interview on 1/27/23 and 2/9/23 with the Licensee/Qualified Professional #2 revealed: - Unable to provide an explanation in regards to no incident report for staff #3 allowing FC #4 to smoke marijuana; - Unable to give an explanation to why there was no IRIS report for the incident on 1/1/23; - The Qualified Professional #1 completed incident reports; - The Qualified Professional #1 completed training on incident reports on 1/29/23	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information;	V 367		

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(2) client identification information;
(3) type of incident;
(4) description of incident;
(5) status of the effort to determine the cause of the incident; and
(6) other individuals or authorities notified or responding.
(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:
(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).
(e) Category A and B providers shall send a

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report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:
(1) medication errors that do not meet the definition of a level II or level III incident;
(2) restrictive interventions that do not meet the definition of a level II or level III incident;
(3) searches of a client or his living area;
(4) seizures of client property or property in the possession of a client;
(5) the total number of level II and level III incidents that occurred; and
(6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to report all critical 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 2 of 3 current clients and Former Client (FC #4). The findings are:

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V 367	Continued From page 33 Review on 1/25/23 of the facility's internal incident reports revealed: -On 1/1/23 staff #1 purchased and smoked marijuana with client #2, #3 and FC #4. Review on 1/24/23 of the IRIS from 10/24/22-1/24/23 revealed: - No IRIS report submitted for incident on 1/1/23, of staff #1 purchased and smoked marijuana with client #2, #3 and FC #4; - No IRIS report submitted for incident that occurred approximately on 12/18/22 of staff #3 allowing FC #4 to smoke marijuana. Review on 1/25/23 of the facility's records revealed: - No documentation of the LME/MCO notification of incident on 1/1/23; - No documentation of LME/MCO notification of incident occurred approximately 12/18/22. Interview on 1/27/23 and 2/9/23 with the Licensee/Qualified Professional #2 revealed: - Unable to provide an explanation in regards to no incident report for staff #3 allowing FC #4 to smoke marijuana; - Unable to give an explanation to why there was no IRIS report for the incident on 1/1/23; - The Qualified Professional #1 completed incident reports; - The Qualified Professional #1 completed training on incident reports on 1/29/23	V 367		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly	V 736		

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V 736	Continued From page 34	V 736		

manner and shall be kept free from offensive odor.

This Rule is not met as evidenced by:
Based on observations and interviews the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are:

Observation on 1/24/23 at approximately 3:35pm of client #2's bedroom revealed:
- 3rd drawer on a 5 drawer dresser is missing knob and broken off from rack causing it to stick out from dresser;
- Crack at top of ceiling on right wall approximately 6 feet long;
- Small wall straight ahead when you walk in room crack in wall approximately 2 feet 4 inches;
- Left/back wall in room crack in ceiling approximately 3.5 inches long
- Left wall in room ceiling had a crack approximately 4 feet long;
- Wall above closet had a crack in ceiling approximately 4.5 feet long;
- Crack going down corner wall of left wall and back wall with window is approximately 7 feet tall.

Observations on 1/24/23 at approximately 3:50pm of client #1's bedroom revealed:
- Hole in right wall is approximately 2 inches wide 3 inches long;
- Crack in lower wall under window approximately 4 inches long.

Observations on 1/24/23 at approximately 4:50pm of client #3's bedroom revealed:
- Hole in left wall approximately 8.5 wide and

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V 736	Continued From page 35 long; - Window, straight ahead when walk into room had a hole around the bottom side of the window approximately 2 inches long; - Window on right side of the room, latch is broken; - Closet door do not close. Interview on 2/9/23 with the Licensee/Qualified Professional revealed: - Planned to call Maintenance and have them to look at all of the things in the home that needed to be prepared and start working on it by next week. This deficiency was cited 2 time(s) on 5/20/21, 5/23/22.	V 736		

Plan of Correction
Harmony House
MHL 036-347

V110: 27G .0204 Training/Supervision of Paraprofessionals

- The following tag has been rectified as of 02/16/2023. Staff member #7 that is referred in the documentation has been trained on Crisis intervention and verbal de-escalation and retrained in NCI training to ensure staff are speaking to clients in a positive and nonconfrontational manner.
- All staff members have been trained in crisis intervention and verbal de-escalation training as of 02/16/2023.
- Staff meeting was held on 2/18/23 to discuss boundaries. It is unclear if clients engaged in smoking marijuana with staff member, but it is apparent that boundaries were crossed with inappropriate conversations amongst staff and the clients. Staff member Olivia Bumgarner was terminated effective 1/30/23.

V293: 27G .1701 Residential Tx. Child/Adol – Scope

- Director [redacted] has met with Qualified Professional [redacted] regarding communication and incident reports. Teams are expected to be notified within 48 hours if an incident occurs.
- Staff are to complete in home incident reports any time there is an incident report in the home. QP [redacted] will also discuss incidents on monthly CFT meetings in addition to sending out an email regarding everything that took place.

V296: 27G. 1704 Residential Tx. Minimum Staffing

- Minimum staffing has been rectified. There are always two staff members on each shift. In the incidents where there are call-outs, coverage is still obtained, and members of management are on call if coverage cannot be obtained.
- If staff quit mid-shift, 90% off Pathways staff live in the area and can get there within 30 minutes as stated in the requirements.
- Director [redacted] monitors time-cards weekly and has been added to the schedule to assist when coverage is needed.

V366: 27G. 0603 Incident Response Requirements

- Director [redacted] provided training to QP Miya Buford and staff on incident reporting on 01/28/23 and 01/29/23.
- QP [redacted] was provided with IRIS manual on 02/01/23 to ensure she is knowledgeable of all requirements and expectations.

- In-Home incident report forms have been printed and provided to group home location to ensure adequate documentation of all incidents in a timely manner. Staff are required to complete incident reports within 24 hours of their shift.

V367: 27G. 0604 Incident Reporting Requirements

- In-Home incident report forms have been printed and provided to group home location to ensure adequate documentation of all incidents in a timely manner. Staff are required to complete incident reports within 24 hours of their shift.
- Director has met with Qualified Professional regarding communication and incident reports. Teams are expected to be notified within 48 hours if an incident occurs.
- Staff are to complete in home incident reports any time there is an incident report in the home. QP will also discuss incidents on monthly CFT meetings in addition to sending out an email regarding everything that took place.
- QP as been trained on how to properly enter IRIS reports on 02/10/23.

V736: 27G .0303 Facility and Grounds Maintenance

- A new dresser was purchased and assembled on 3/3/2023.
- All cracks in the ceiling have been rectified as of 3/14/2023.
- All holes in the wall were fixed effective 2/28/2023.
- The hole in the window seal was fixed effective 3/14/2023.