

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL018-102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2023
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NAME OF PROVIDER OR SUPPLIER PINNACLE THERAPEUTIC SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 2329 SPRINGS ROAD, NORTH EAST HICKORY, NC 28601
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	<p>INITIAL COMMENTS</p> <p>A complaint survey was completed on April 19, 2023. The complaint was substantiated (Intake #NC00200641). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC .5100 Community Respite Services for Individuals of All Disability Groups (Day - 6). 10A NCAC .5100 Community Respite Services for Individuals of All Disability Groups (Residential - 6).</p> <p>This facility is licensed for 6 residential and currently has a census of 5. The survey sample consisted of audits of 5 current clients and 4 former clients.</p> <p>This facility was licensed on 2-3-23 and has served clients since 2-9-23.</p>	V 000		
V 105	<p>27G .0201 (A) (1-7) Governing Body Policies</p> <p>10A NCAC 27G .0201 GOVERNING BODY POLICIES</p> <p>(a) The governing body responsible for each facility or service shall develop and implement written policies for the following:</p> <p>(1) delegation of management authority for the operation of the facility and services;</p> <p>(2) criteria for admission;</p> <p>(3) criteria for discharge;</p> <p>(4) admission assessments, including:</p> <p>(A) who will perform the assessment; and</p> <p>(B) time frames for completing assessment.</p> <p>(5) client record management, including:</p> <p>(A) persons authorized to document;</p> <p>(B) transporting records;</p> <p>(C) safeguard of records against loss, tampering, defacement or use by unauthorized persons;</p>	V 105		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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V 105	<p>Continued From page 1</p> <p>(D) assurance of record accessibility to authorized users at all times; and</p> <p>(E) assurance of confidentiality of records.</p> <p>(6) screenings, which shall include:</p> <p>(A) an assessment of the individual's presenting problem or need;</p> <p>(B) an assessment of whether or not the facility can provide services to address the individual's needs; and</p> <p>(C) the disposition, including referrals and recommendations;</p> <p>(7) quality assurance and quality improvement activities, including:</p> <p>(A) composition and activities of a quality assurance and quality improvement committee;</p> <p>(B) written quality assurance and quality improvement plan;</p> <p>(C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services;</p> <p>(D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service;</p> <p>(E) strategies for improving client care;</p> <p>(F) review of staff qualifications and a determination made to grant treatment/habilitation privileges:</p> <p>(G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death;</p> <p>(H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted</p>	V 105		

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V 105	<p>Continued From page 2</p> <p>methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement policies including admission assessments and discharge summaries. The findings are:</p> <p>Review on 4-18-23 of the facility's "Policies and Procedures Revised 12/22" revealed: -"Admission Assessments... Overview. Pinnacle Therapeutic Services strives to address the specific needs and goals of each individual client ...staff will administer specific assessments to gather information on client needs. Procedures 1) The Beck Hopelessness Scale (BHS) will be administered and completed by the client within 24 hours of admission... 2) The Adverse Childhood Experiences (ACES) Questionnaire will be administered and completed by client within 72 hours of admission... 3) The Rosenberg Self-Esteem Scale will be administered and completed by the client within 72 hours of admission... 4) The Massachusetts Youth Screening Instrument (MAYSI-2) will be administered and completed by the client within 72 hours of</p>	V 105		

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V 105	<p>Continued From page 3</p> <p>admission. This inventory identifies youth who may have mental health needs...</p> <p>5) ...A Comprehensive Clinical Assessment (CCA) must be completed by a licensed therapist prior to billing...within 72 hours of admission..."</p> <p>- "Discharge...</p> <p>h. Discharge documentation:</p> <p>i. Reviews/updates to the discharge plan are documented in CFT (Child and Family Team) meeting notes.</p> <p>ii. A Discharge Summary will be completed by the assigned program staff prior to the youth's discharge when it is planned within 72 hours. If the discharge is unplanned, the discharge summary will be completed within 72 hours of the discharge date..."</p> <p>- "Intake and Assessment. Overview...Clients are only admitted for which Pinnacle Therapeutic Services staff can provide appropriate care and services... Procedures...</p> <p>5). Admission and Authorization Paperwork</p> <p>a. A service plan is required at admission and constitutes the service order...The service order must be based on a comprehensive clinical assessment of the beneficiary's needs..."</p> <p>Review on 4-12-23 of Client #1's record revealed:</p> <p>-Age: 16 years old.</p> <p>-Date of admission 2-24-23.</p> <p>-Diagnoses: Attention Deficit Hyperactivity Disorder (ADHD), Disruptive Mood Dysregulation, Post Traumatic Stress Disorder (PTSD), Conduct Disorder and Unspecified Personality Disorder.</p> <p>-No evidence of a CCA, service plan, or admission screening to include BHS, ACES, Rosenberg Self-Esteem Scale, and MAYSI-2.</p> <p>Review on 4-12-23 of Client #2's record revealed:</p> <p>-Age: 16 years old.</p>	V 105		

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V 105	<p>Continued From page 4</p> <p>-Date of Admission: 2-21-23. -Diagnoses: Per local hospital discharge summary dated 2-21-23 Bipolar Disorder, Rare Mixed with Psychotic Effects; PTSD; Rule Out (R/O) ADHD; Oppositional Defiant Disorder (ODD); Cluster B Personality Traits. -No evidence of a CCA, service plan, or admission screening to include BHS, ACES, Rosenberg Self-Esteem Scale, and MAYSI-2.</p> <p>Review on 4-12-23 of Client #3's record revealed: -Age: 12 years old. -Date of Admission: 3-1-23. -Diagnoses: -Per local hospital document dated 2-15-23 Disruptive Mood Dysregulation Disorder. -Per application dated 3-1-23 ODD, Moderate; ADHD; PTSD. -No evidence of a CCA, service plan, or admission screening to include BHS, ACES, Rosenberg Self-Esteem Scale, and MAYSI-2.</p> <p>Review on 4-12-23 of Client #4's record revealed: -Age: 15 years old. -Date of Admission: 2-23-23. -Diagnoses: Not identified in the record. -Admission application dated 2-23-23 "Client wants to work on attitude and anger." -No evidence of a CCA, service plan, or admission screening to include BHS, ACES, Rosenberg Self-Esteem Scale, and MAYSI-2.</p> <p>Review on 4-19-23 of Client #5's record revealed: -Age: 16 years old. -Date of Admission: 4-10-23. -Diagnoses: Conduct Disorder. -No evidence of service plan or admission screening to include BHS, ACES, Rosenberg Self-Esteem Scale, and MAYSI-2. -CCA dated 4-10-23 and faxed to the provider on</p>	V 105		

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V 105	<p>Continued From page 5</p> <p>4-12-23.</p> <p>Review on 4-12-23 of Former Client (FC) #6's record revealed: -Age: 15 years old. -Date of Admission: 2-15-23. -Date of Discharge: Not identified in the record. -Diagnoses: Not identified in the record. -No evidence of a CCA, service plan, admission screening to include BHS, ACES, Rosenberg Self-Esteem Scale, and MAYSI-2 or discharge summary.</p> <p>Review on 4-12-23 of FC #7's record revealed: -Age: 15 years old. -Date of Admission: 2-19-23. -Date of Discharge: Not identified in the record. -Diagnoses: Per application dated 2-19-23 ADHD; PTSD. -No evidence of a CCA, service plan, admission screening to include BHS, ACES, Rosenberg Self-Esteem Scale, and MAYSI-2, or discharge summary.</p> <p>Review on 4-13-23 of FC #8's record revealed: -Age: 15 years old. -Date of Admission: 3-1-23. -Date of Discharge: 3-12-23. -Diagnoses: -Per CCA addendum dated 9-26-22 Adjustment Disorder, Anxiety, Oppositional Defiant Disorder. -Per application dated 3-1-23 no diagnoses listed. -No evidence of a service plan, admission screening to include BHS, ACES, Rosenberg Self-Esteem Scale, and MAYSI-2, or discharge summary.</p> <p>Review on 4-17-23 of FC #9's record revealed:</p>	V 105		

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V 105	<p>Continued From page 6</p> <ul style="list-style-type: none"> -Age: 16 years old. -Date of Admission: No evidence in record. -Date of Discharge: No evidence in record. -Diagnoses: not present in file. -No evidence of a CCA, service plan, admission screening to include BHS, ACES, Rosenberg Self-Esteem Scale, and MAYSII-2, or discharge summary. <p>Review on 4-12-23 of a form titled "Pinnacle Therapeutic Services Monthly Headcount Sheet February 2023" provided by the Licensee on 4-12-23 revealed:</p> <ul style="list-style-type: none"> -FC #9 was admitted to the facility on 2-9-23. -FC #9 was discharged from the facility on 2-28-23. <p>Review on 4-19-23 of the Local Police Department Incident/Investigation Reports revealed:</p> <ul style="list-style-type: none"> -4-12-23 at 5:02 pm law enforcement responded to Pinnacle Therapeutic Services "in reference to a civil disturbance..." (Law Enforcement Officer/LEO) spoke with the owner (Licensee) of the facility who advised that they had spent a large sum of money to open the facility ...that when he selected the first kids to stay in the home, he did not look into the backgrounds of the children to ensure they (staff) could provide adequate care. The owner (Licensee) advised that he just picked the first several children to allow the facility to get money. The owner (licensee) advised he was attempting to get several of the children rehomed as their facility was not at the level needed for those children." <p>Interview on 4-17-23 with the Qualified Professional/Program Director (QP/PD) revealed:</p> <ul style="list-style-type: none"> -"No, they (clients) do not have to have a 	V 105		

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V 105	<p>Continued From page 7</p> <p>diagnosis to be placed but we (Pinnacle Therapeutic Services) have to be a bit more careful when we take clients on a higher level." -"If a client has diagnoses, we (Pinnacle Therapeutic Services) require that we get a current PCP (Person Centered Plan) and CCA (Comprehensive Clinical Assessment)..." -"We have the assessments and those are done with their social worker upon intake to inform us when the individual is coming and there are 4 assessments supposed to be with the intake paperwork to tell us things like if they are suicidal and what mood they are in." -Admitted that the files were "...Displaced I guess, everything is spread out and I have to get my stuff together..." -Did not acknowledge that there were no discharge summaries in the client records but stated "We have only had 2 discharges." -"[FC #7] was officially discharged, I didn't do her paperwork because when she did the runaway we spoke with [client's guardian]..."</p> <p>Interview on 4-17-23 and 4-19-23 with the Licensee revealed: -"We had several PRTF (Psychiatric Residential Treatment Facility) kids. We have worked diligently to address any issues. They (Clients) have specific issues. We have CCA's..." -"We need to do a better job in understanding the potential care for the client that is needed." -"Obviously they have not (assessments being completed) and we have missed the ball in that area...."</p> <p>This deficiency is cross referenced into 10A NCAC 27E .0101 Least Restrictive Alternative (V513) for a Type A1 rule violation and must be corrected within 23 days.</p>	V 105		

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V 107	Continued From page 8	V 107		
V 107	<p>27G .0202 (A-E) Personnel Requirements</p> <p>10A NCAC 27G .0202 PERSONNEL REQUIREMENTS</p> <p>(a) All facilities shall have a written job description for the director and each staff position which:</p> <ul style="list-style-type: none"> (1) specifies the minimum level of education, competency, work experience and other qualifications for the position; (2) specifies the duties and responsibilities of the position; (3) is signed by the staff member and the supervisor; and (4) is retained in the staff member's file. <p>(b) All facilities shall ensure that the director, each staff member or any other person who provides care or services to clients on behalf of the facility:</p> <ul style="list-style-type: none"> (1) is at least 18 years of age; (2) is able to read, write, understand and follow directions; (3) meets the minimum level of education, competency, work experience, skills and other qualifications for the position; and (4) has no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry. <p>(c) All facilities or services shall require that all applicants for employment disclose any criminal conviction. The impact of this information on a decision regarding employment shall be based upon the offense in relationship to the job for which the applicant is applying.</p> <p>(d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided.</p> <p>(e) A file shall be maintained for each individual</p>	V 107		

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V 107	<p>Continued From page 9</p> <p>employed indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification.</p> <p>This Rule is not met as evidenced by: Based on record reviews, observation and interviews, the facility failed to maintain a personnel file with required documentation affecting 1 of 1 Licensee, 11 of 11 current paraprofessional staff (Staff #'s 1-11) and 2 of 2 Former Staff (FS#12 and #13). The findings are:</p> <p>Review on 4-13-23 of Staff #1-#3, #7-#11, FS #12 and Licensee's personnel record revealed: -No evidence of date of hire. -No evidence of job title. -No evidence of a signed job description nor education credentials.</p> <p>Review on 4-13-23 of Staff #4-#6 and FS #13's personnel record revealed: -No evidence of date of hire. -No evidence of job title. -No evidence of a signed job description.</p> <p>Record review and interviews with staff during the survey regarding requests for personnel records revealed: -Personnel records were not received from Staff #1 as requested on 4-12-23. -A second request made to Staff #1 on 4-13-23 at</p>	V 107		

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V 107	<p>Continued From page 10</p> <p>8:55 am.</p> <p>-A request to Staff #5 on 4-13-23 for the personnel record of the Licensee.</p> <p>-Records for Staff #'s 1-10 and FS #13 were provided by Staff #1 on 4-13-23 at 9:10 am.</p> <p>-On 4-13-23 at 11:18 am, the Licensee stated that he would have to go to his office for the FS #12's personnel record.</p> <p>-On 4-13-23 at 2:52 pm, another request was made to the Licensee for the personnel record of FS #12 and a first request was made for the personnel record of Staff #11 (who was observed working on 4-11-23). The Licensee stated "He (Staff #11) just started here. He has only worked for a week, so I don't have much of a file on him. I can get what I have available, like his application." (which was never provided during the survey).</p> <p>-On 4-13-23 at 3:00 pm the Licensee provided the personnel record for FS #12.</p> <p>-On 4-17-23 an additional request was made for the personnel record of Staff #11 that was never received.</p> <p>Interview on 4-13-23 with Staff #5 revealed: -"[Licensee] is the owner so I don't think he has a file." She would call the Licensee and ask him.</p> <p>Interview on 4-13-23 with the Licensee revealed: -" ...but I am not an employee, I just handle the business, you may have seen me talking to her (Client #4) yesterday (during an incident when Client #4 had a sharp object); I don't do care."</p> <p>Interview on 4-17-23 with FS #12 revealed: -The Licensee provided direct care. "...He also worked some third shifts as well..."</p> <p>Observation and interview on 4-12-23 at 2:48 pm with Staff #1 revealed:</p>	V 107		

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V 107	<p>Continued From page 11</p> <p>-"[Client #4] is outside with [Licensee] right now..."</p> <p>-DHSR surveyors could see through a set of french doors that the Licensee and Client #4 were outside of the facility on the front porch. No other staff were present outside with the Licensee and Client #4.</p> <p>Interview on 4-17-23 and 4-19-23 with the Qualified Professional (QP)/Program Director (PD) revealed:</p> <p>-"I'm looking for [Staff #11]'s chart."</p> <p>-For personnel records "My role is supposed to be to sit in with hiring, do the reference checks, ensure staff are in mandatory trainings and certifications for ADA (Adaptive De-Escalation Alternatives)."</p> <p>Interview on 4-19-23 with the Licensee revealed:</p> <p>-"I've been keeping up personnel records currently but we are bringing in a person to do it on a daily basis."</p> <p>-In the meantime, "I will be responsible."</p> <p>-He did not have a file, " ...(I'm) here for strictly business and don't get involved in incidents and stuff going on here."</p> <p>-Stated upon getting licensed, "They asked if I was going to work in the house. I said no. They (Division of Health Service Regulation initial licensure) said I need Health Care Personnel Registry (HCPR) and background (checks) and that's all I did."</p> <p>-Provided a single document of an HCPR check dated 12-1-22 and no other personnel documents.</p> <p>This deficiency is cross referenced into 10A NCAC 27E .0101 Least Restrictive Alternative (V513) for a Type A1 rule violation and must be corrected within 23 days.</p>	V 107		

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V 108	Continued From page 12	V 108		
V 108	<p>27G .0202 (F-I) Personnel Requirements</p> <p>10A NCAC 27G .0202 PERSONNEL REQUIREMENTS</p> <p>(f) Continuing education shall be documented.</p> <p>(g) Employee training programs shall be provided and, at a minimum, shall consist of the following:</p> <p>(1) general organizational orientation;</p> <p>(2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B;</p> <p>(3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and</p> <p>(4) training in infectious diseases and bloodborne pathogens.</p> <p>(h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction.</p> <p>(i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.</p>	V 108		

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V 108	<p>Continued From page 13</p> <p>This Rule is not met as evidenced by: Cross-Reference 10A NCAC 27G .0202 Personnel Requirements (V108). Based on record reviews, observation and interviews, the facility failed to maintain a personnel file with required documentation consisting of training programs of client rights/confidentiality, meeting the clients needs as specified in the treatment/habilitation plan, and infectious disease/blood borne pathogens affecting 1 of 1 Licensee, 11 of 11 current paraprofessional staff (Staff #'s 1-11) and 2 of 2 Former Staff (FS#12 and #13). The findings are:</p> <p>Review on 4-13-23 of Staff #1-#3, #5 and #7-#10's personnel record revealed: -No evidence of date of hire. -No evidence of job title. -No evidence of training to meet the mental health /developmental disabilities/substance abuse (mh/dd/sa) needs of the clients as specified in the treatment/habilitation plan.</p> <p>Review on 4-13-23 of Staff #4, #11, FS #12 and the Licensee's personnel record revealed: -No evidence of date of hire. -No evidence of job title. -No evidence of training to meet the mental health /developmental disabilities/substance abuse (mh/dd/sa) needs of the clients as specified in the treatment/habilitation plan. -No evidence of training in infectious disease/blood borne pathogens.</p> <p>Review on 4-13-23 of Staff #6's personnel record revealed: -No evidence of date of hire. -No evidence of job title. -No evidence of training to meet the mental health /developmental disabilities/substance</p>	V 108		

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V 108	<p>Continued From page 14</p> <p>abuse (mh/dd/sa) needs of the clients as specified in the treatment/habilitation plan.</p> <p>Review on 4-13-23 of FS #13's personnel record revealed: -No evidence of date of hire. -No evidence of job title. -No evidence of training in client rights/confidentiality and infectious disease/blood borne pathogens.</p> <p>Record review and interviews with staff during the survey regarding requests for personnel records revealed: -Personnel records were not received from Staff #1 as requested on 4-12-23. -A second request made to Staff #1 on 4-13-23 at 8:55 am. -A request to Staff #5 on 4-13-23 for the personnel record of the Licensee. -Records for Staff #'s 1-10 and FS #13 were provided by Staff #1 on 4-13-23 at 9:10 am. -On 4-13-23 at 11:18 am, the Licensee stated that he would have to go to his office for the FS #12's personnel record. -On 4-13-23 at 2:52 pm, another request was made to the Licensee for the personnel record of FS #12 and a first request was made for the personnel record of Staff #11 (who was observed working on 4-11-23). The Licensee stated "He (Staff #11) just started here. He has only worked for a week, so I don't have much of a file on him. I can get what I have available, like his application." (which was never provided during the survey). -On 4-13-23 at 3:00 pm the Licensee provided the personnel record for FS #12. -On 4-17-23 an additional request was made for the personnel record of Staff #11 that was never received.</p>	V 108		

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V 108	<p>Continued From page 15</p> <p>Observation and interview on 4-12-23 at 2:48 pm with Staff #1 revealed: -Staff #1 approached DHSR (Division of Health and Service Regulation) surveyors and stated "I'm locking y'all (surveyors) in here out of concern for your safety. [Client #4] is showing out and just tossed water all over the computer in the office and broke a pair of scissors." -Staff #1 stated that Client #4 was outside with the Licensee "...right now and she has the other half (of the scissors)". -DHSR surveyors observed the Licensee and Client #4 outside on the front porch with no other staff.</p> <p>Interview on 4-13-23 with Staff #5 revealed: -"[Licensee] is the owner so I don't think he has a file." She would call the Licensee and ask him.</p> <p>Interview on 4-13-23 with the Licensee revealed: -"...but I am not an employee, I just handle the business, you may have seen me talking to her (Client #4) yesterday (during an incident when Client #4 had a sharp object); I don't do care."</p> <p>Interview on 4-17-23 with FS #12 revealed: -The Licensee provided direct care. "...He also worked some third shifts as well..."</p> <p>Interview on 4-17-23 and 4-19-23 with the Qualified Professional/Program Director (QP/PD) revealed: -"I'm looking for [Staff #11]'s chart." -For personnel records "My role is supposed to be to sit in with hiring, do the reference checks, ensure staff are in mandatory trainings and certifications for ADA (Adaptive De-Escalation Alternatives)." -"He (Licensee) is present, he has been here a</p>	V 108		

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V 108	<p>Continued From page 16</p> <p>couple of times with the kids ..."</p> <p>Interview on 4-19-23 with the Licensee revealed: -"I've been keeping up personnel records currently but we are bringing in a person to do it on a daily basis." -In the meantime, "I will be responsible." -Stated that he did not have a file, " ...(I'm) here for strictly business and don't get involved in incidents and stuff going on here." -Stated upon getting licensed, "They asked if I was going to work in the house. I said no. They (Division of Health Service Regulation initial licensure) said I need Health Care Personnel Registry (HCPR) and background (checks) and that's all I did." -Provided a single document of an HCPR check dated 12-1-22 and no other personnel documents.</p> <p>This deficiency is cross referenced into 10A NCAC 27E .0101 Least Restrictive Alternative (V513) for a Type A1 rule violation and must be corrected within 23 days.</p>	V 108		
V 109	<p>27G .0203 Privileging/Training Professionals</p> <p>10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS</p> <p>(a) There shall be no privileging requirements for qualified professionals or associate professionals.</p> <p>(b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served.</p> <p>(c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence.</p>	V 109		

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V 109	<p>Continued From page 17</p> <p>(d) Competence shall be demonstrated by exhibiting core skills including:</p> <ol style="list-style-type: none"> (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. <p>(e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS.</p> <p>(f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional.</p> <p>(g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, 1 of 1 Qualified Professional/Program Director (QP/PD) failed to demonstrate the knowledge, skills, and abilities required by the population served. The findings are:</p> <p>Review on 4-13-23 of the QP/PD's Personnel Record revealed: -Date of Hire: not identified in the record. -Certificate of Training titled "Identifying and</p>	V 109		

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V 109	<p>Continued From page 18</p> <p>Responding to Child Abuse and Neglect" dated 6-1-22.</p> <p>Refer to V105 for evidence the QP/PD failed to implement policies regarding paperwork including admission assessments and discharge summaries.</p> <p>Refer to V107 and V108 for evidence the QP/PD failed to maintain personnel files and ensure required training was completed.</p> <p>Refer to V111 for evidence the QP/PD failed to ensure client assessments were completed prior to the delivery of services and that strategies to address clients' presenting problems were documented.</p> <p>Refer to V112 for evidence the QP/PD failed to develop and implement treatment strategies to address clients' needs.</p> <p>Refer to V113 for evidence the QP/PD failed to maintain clients' records.</p> <p>Refer to V118 for evidence the QP/PD failed to ensure: -medications were administered to clients on the written order of a person authorized to prescribe medications. -medications were administered only by persons trained by a registered nurse, pharmacist, or other legally qualified person and privileged to prepare and administer medications. -medication administration records (MARs) were kept current.</p> <p>Refer to V123 for evidence the QP/PD failed to ensure medication errors were reported immediately to a physician, or pharmacist.</p>	V 109		

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V 109	<p>Continued From page 19</p> <p>Refer to V131 for evidence the QP/PD failed to access the Health Care Personnel Registry (HCPR) before hiring health care personnel into the facility.</p> <p>Refer to V132 for evidence the QP/PD failed to ensure: -all allegations of abuse made against health care personnel were reported to HCPR. -all allegations of abuse were investigated. -all clients were protected from harm during investigations of allegations of abuse.</p> <p>Refer to V133 for evidence the QP/PD failed to request a criminal history record check within 5 days of an offer of employment.</p> <p>Refer to V138 for evidence the QP/PD failed to ensure that the facility served no more clients than the number for which it was licensed.</p> <p>Refer to V366 for evidence the QP/PD failed to implement written policies governing the response to level I, II or III incidents.</p> <p>Refer to V367 for evidence the QP/PD failed to report level II and level III incidents to the Local Management Entity (LME)/Managed Care Organization (MCO) within 72 hours of becoming aware of the incidents.</p> <p>Refer to V500 for evidence the QP/PD failed to ensure all instances of alleged abuse were reported to the local Department of Social Services (DSS).</p> <p>Interview on 4-17-23 with the QP/PD revealed: -Duties were "to oversee the function of the house, applications, intake of clients and the daily</p>	V 109		

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V 109	<p>Continued From page 20</p> <p>function of the house is being operated ...My role is supposed to sit in with hiring, do the reference checks, ensure staff are in mandatory trainings ..."</p> <p>-Facility records were "displaced I guess, everything is spread out and I have to get my stuff together ..."</p> <p>-He was responsible for ensuring the HCPR was accessed. " ...I am supposed to follow up, as I am the supervisor ..."</p> <p>-He was aware criminal background checks had not been completed on staff and planned to create "a spreadsheet to ensure it's being done."</p> <p>-He stated, "I am ultimately responsible for incident reports ...I have a couple of incident reports that didn't get in the system (North Carolina Incident Response Improvement System) ...I missed that and it's the first place it needs to go. I dropped the ball on that, and I will use policies and procedures when it comes to incident reports ...I need to do a better job with the investigation and documentation piece ..."</p> <p>-He had not completed incident reports for law enforcement responses to the facility.</p> <p>-He had been following the criteria for a 1300 program (Residential Treatment for Children or Adolescents) instead of what the facility was licensed for.</p> <p>Interview on 4-19-23 with the Licensee revealed: -He planned to hire a Quality Assurance/Quality Improvement staff to provide oversight.</p> <p>This deficiency is cross referenced into 10A NCAC 27E .0101 Least Restrictive Alternative (V513) for a Type A1 rule violation and must be corrected within 23 days.</p>	V 109		

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V 111	Continued From page 21	V 111		
V 111	<p>27G .0205 (A-B) Assessment/Treatment/Habilitation Plan</p> <p>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</p> <p>(a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to:</p> <ol style="list-style-type: none"> (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. <p>(b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.</p>	V 111		

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V 111	<p>Continued From page 22</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that assessments were completed prior to the delivery of services affecting 4 of 5 current clients (#1-#3 and #5) and 2 of 4 Former Clients (FC #8 and #9) and failed to document strategies to address the client's presenting needs affecting 5 of 5 current Clients (#1-#5) and 4 of 4 Former Clients (FC #6-#9). The findings are:</p> <p>Review on 4-12-23 of Client #1's record revealed: -Age: 16 years old. -Date of admission 2-24-23. -Diagnoses: Attention Deficit Hyperactivity Disorder (ADHD); Disruptive Mood Dysregulation; Post Traumatic Stress Disorder (PTSD); Conduct Disorder; Unspecified Personality Disorder. -No evidence of assessments as appropriate to the client's needs. -No strategies documented to address presenting needs.</p> <p>Review on 4-12-23 of Client #2's record revealed: -Age: 16 years old. -Date of Admission: 2-21-23. -Diagnoses: Per local hospital discharge summary dated 2-21-23 Bipolar Disorder, Rare Mixed with Psychotic Effects; PTSD; Rule Out (R/O) ADHD; Oppositional Defiant Disorder (ODD); Cluster B Personality Traits. -No evidence of assessments as appropriate to the client's needs. -No strategies documented to address presenting needs.</p> <p>Review on 4-12-23 of Client #3's record revealed: -Age: 12 years old. -Date of Admission: 3-1-23.</p>	V 111		

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V 111	<p>Continued From page 23</p> <p>-Diagnoses: -Per local hospital document dated 2-15-23 Disruptive Mood Dysregulation Disorder. -Per application dated 3-1-23 ODD, Moderate; ADHD; PTSD.</p> <p>-No evidence of assessments as appropriate to the client's needs. -No strategies documented to address presenting needs.</p> <p>Review on 4-12-23 of Client #4's record revealed: -Age: 15 years old. -Date of Admission: 2-23-23. -Diagnoses: Not identified in the record. -Application dated 2-23-23 "Client wants to work on attitude and anger." -No evidence of assessments as appropriate to the client's needs. -No strategies documented to address presenting needs.</p> <p>Review on 4-19-23 of Client #5's record revealed: -Age: 16 years old -Date of Admission: 4-10-23. -Diagnoses: Conduct Disorder. -No evidence of assessments as appropriate to the client's needs. -Comprehensive Clinical Assessment (CCA) dated 4-10-23 and faxed to the provider on 4-12-23 (per fax transmittal cover sheet by legal guardian) indicated a history of "suicidal remarks, self-harm and aggressive behaviors ...when she feels her independence is threatened, she will either lash out physically or run away ...Due to client behaviors including elopement, her team has had difficulty locating long term placement ...Client has a significant trauma history including physical abuse, sexual abuse and reportedly human trafficking. Client is also currently on probation ...Client takes minimal responsibility for</p>	V 111		

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V 111	<p>Continued From page 24</p> <p>her choices and has shown little insight into her choices and related concerns for her safety ...She continues to be at risk unless placed under close 24/7 supervision given her frequent elopement and history of trafficking. Placement at a PRTF (Psychiatric Residential Treatment Facility) ...DJJ (Department of Juvenile Justice) documentation indicates that client has run away numerous times and has been passed around for sex by adult men while she was on the run ..."</p> <p>-No strategies documented to address presenting needs.</p> <p>Review on 4-12-23 of FC #6's record revealed: -Age: 15 years old. -Date of Admission: 2-15-23. -Date of Discharge: Not identified in the record. -Diagnoses: Not identified in the record. -Application dated 2-15-23 indicated "Expected stay is 90 days. Needs to follow up with a medication management appointment within the next two weeks ...Youth has three weeks of medication upon arriving at placement." -No evidence of assessments as appropriate to the client's needs -No strategies documented to address presenting needs.</p> <p>Review on 4-12-23 of FC #7's record revealed: -Age: 15 years old. -Date of Admission: 2-19-23. -Date of Discharge: Not identified in the record. -Diagnoses: Per application dated 2-19-23 ADHD; PTSD. -Application dated 2-19-23 indicated "Details relative to placement. [FC#7] needs placement long term, placement disrupted since 1/16 however been in fictive kinship placement. There is a question about aggressive behaviors." -No evidence of assessments as appropriate to</p>	V 111		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 111	<p>Continued From page 25</p> <p>the client's needs -No strategies documented to address presenting needs.</p> <p>Review on 4-13-23 of FC #8's record revealed: -Age: 15 years old. -Date of Admission: 3-1-23. -Date of Discharge: 3-12-23. -Diagnoses: -Per CCA addendum dated 9-26-22 adjustment disorder anxiety, oppositional defiant disorder. -Per application dated 3-1-23 no diagnoses listed. -No evidence of assessments as appropriate to the client's needs -No strategies documented to address presenting needs.</p> <p>Review on 4-17-23 of FC #9's record revealed: -Age: 16 years old. -Date of Admission: No evidence in record. -Date of Discharge: No evidence in record. -Diagnoses: not present in file. -No evidence of assessments as appropriate to the client's needs -No strategies documented to address presenting needs.</p> <p>Review on 4-12-23 of a form titled "Pinnacle Therapeutic Services Monthly Headcount Sheet February 2023" provided by the Licensee on 4-12-23 revealed: -FC #9 was admitted to the facility on 2-9-23. -FC #9 was discharged from the facility on 2-28-23.</p> <p>Interview on 4-17-23 with the Qualified Professional/Program Director (QP/PD) revealed: -Responsibilities included intake of new clients.</p>	V 111		

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V 111	<p>Continued From page 26</p> <p>-"Our intake we do require a current PCP (Person Centered Plan), CCA and they're scheduled to participate every 30 days for treatment planning." -" ...We go off the DSS (Department of Social Services) Person Centered Plan and we give an update ..." " ...I have about 6 of them (client assessments) done in total ...everything is spread out and I have to get my stuff together."</p> <p>Interview on 4-19-23 with the Licensee revealed: -The QP/PD was responsible for admissions. -"We just opened and took the first 6 or 7 (Clients) and we are going to implement taking those we can provide for ..." -"I will say obviously not ...No we have not done a good job of doing it. (following admission criteria)" -"Has it been done in the past, I would say it has not."</p> <p>This deficiency is cross referenced into 10A NCAC 27E .0101 Least Restrictive Alternative (V513) for a Type A1 rule violation and must be corrected within 23 days.</p>	V 111		
V 112	<p>27G .0205 (C-D) Assessment/Treatment/Habilitation Plan</p> <p>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a</p>	V 112		

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V 112	<p>Continued From page 27</p> <p>projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement treatment strategies to address the needs of the clients affecting 4 of 5 current Clients (Clients #1-4) and 2 of 4 Former Clients (FC #6 and #7). The findings are:</p> <p>Review on 4-12-23 of Client #1's record revealed: -Age: 16 years old. -Date of admission 2-24-23. -Diagnoses: Attention Deficit Hyperactivity Disorder (ADHD); Disruptive Mood Dysregulation; Post Traumatic Stress Disorder (PTSD); Conduct Disorder; Unspecified Personality Disorder. -No documented treatment plan that included treatment strategies.</p>	V 112		

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V 112	<p>Continued From page 28</p> <p>Review on 4-12-23 of Client #2's record revealed: -Age: 16 years old. -Date of Admission: 2-21-23. -Diagnoses: Per local hospital discharge summary dated 2-21-23 Bipolar Disorder, Rare Mixed with Psychotic Effects; PTSD; Rule Out (R/O) ADHD; Oppositional Defiant Disorder (ODD); Cluster B Personality Traits. -"Written Plan of Care" dated 2-21-23 documented the following two agency goals: "Goal #1 Youth to learn the rules and regulations of the program and implement them as needed for the next 30 days ..." "Goal #2 Youth to continue all medical appointments as scheduled for the next 30 days ..." -The Written Plan of Care did not document staff responsible, schedule for review, basis for evaluation/assessment of outcome achievement, strategies and interventions.</p> <p>Review on 4-12-23 of Client #3's record revealed: -Age: 12 years old. -Date of Admission: 3-1-23. -Diagnoses: -Per local hospital document dated 2-15-23 Disruptive Mood Dysregulation Disorder. -Per application dated 3-1-23 ODD, Moderate; ADHD; PTSD. -No documented treatment plan that included treatment strategies.</p> <p>Review on 4-12-23 of Client #4's record revealed: -Age: 15 years old. -Date of Admission: 2-23-23. -Diagnoses: Not identified in the record. -No documented treatment plan that included treatment strategies.</p> <p>Review on 4-12-23 of FC #6's record revealed:</p>	V 112		

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V 112	<p>Continued From page 29</p> <p>-Age: 15 years old. -Date of Admission: 2-15-23. -Date of Discharge: Not identified in the record. -Diagnoses: Not identified in the record. -No documented treatment plan that included treatment strategies.</p> <p>Review on 4-12-23 of FC #7's record revealed: -Age: 15 years old. -Date of Admission: 2-19-23. -Date of Discharge: Not identified in the record. -Diagnoses: Per application dated 2-19-23 ADHD; PTSD. -No documented treatment plan that included treatment strategies.</p> <p>Interview on 4-11-23 with Client #1 revealed: -Was not aware of any treatment goals. -"They (staff) don't deal with behaviors, if they can't get the person or situation under control, they call the police. You (clients) are kind of stuck in a loop here...They (staff) are not qualified to deal with behaviors..."</p> <p>Interview on 4-11-23 with Client #3 revealed: -"Police are here a lot because the staff calls them because the staff don't know where to take us because the hospital or the police is their only options and resources. When clients get upset that's the only thing that they do is call the police, call the police. They don't do anything else..."</p> <p>Interview on 4-13-23 with Staff #1 revealed: -"Even though they (clients) are here 90 days, I try to set goals for them to do better."</p> <p>Interview on 4-13-23 with Staff #5 revealed: -The clients did not have goals.</p> <p>Interview on 4-17-23 with the Qualified</p>	V 112		

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V 112	<p>Continued From page 30</p> <p>Professional/Program Director (QP/PD) revealed: -"We go off the DSS (Department of Social Services) Person Centered Plan and we give an update and we follow up on the education and see if we can move forward for individual therapy because it can be done by [electronic communication] and if not we will seek those services in [local city] right here near our place."</p> <p>Interview on 4-19-23 with the Licensee revealed: -"We are going to require that we have information before they come in and we will be a part of the conversation to update treatment plans and how the clients are doing." -The facility would be responsible for treatment planning "After it is handed off to us and we have completed a PCP (Person Centered Plan) with our goals. There will be 72 hours for us to have access to all information and we will do a treatment plan update."</p> <p>This deficiency is cross referenced into 10A NCAC 27E .0101 Least Restrictive Alternative (V513) for a Type A1 rule violation and must be corrected within 23 days.</p>	V 112		
V 113	<p>27G .0206 Client Records</p> <p>10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date;</p>	V 113		

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V 113	<p>Continued From page 31</p> <p>(F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain client records affecting 5</p>	V 113		

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V 113	<p>Continued From page 32</p> <p>of 5 current Clients (#1-#5) and 4 of 4 Former Clients (FC #6-#9). The findings are:</p> <p>Review on 4-12-23 of Client #1's record revealed: -Age: 16 years old. -Date of admission 2-24-23. -Diagnoses: Attention Deficit Hyperactivity Disorder (ADHD); Disruptive Mood Dysregulation; Post Traumatic Stress Disorder (PTSD); Conduct Disorder; Unspecified Personality Disorder. -No documentation of an identification face sheet. -No documentation of the screening and assessment. -No documentation of a treatment/habilitation or service plan. -No documentation of services provided. -No documentation of progress towards outcomes.</p> <p>Review on 4-12-23 of Client #2's record revealed: -Age: 16 years old. -Date of Admission: 2-21-23. -Diagnoses: Per local hospital discharge summary dated 2-21-23 Bipolar Disorder, Rare Mixed with Psychotic Effects; PTSD; Rule Out (R/O) ADHD; Oppositional Defiant Disorder (ODD); Cluster B Personality Traits. -No documentation of an identification face sheet. -No documentation of the screening and assessment. -No documentation of services provided. -No documentation of progress towards outcomes.</p> <p>Review on 4-12-23 of Client #3's record revealed: -Age: 12 years old. -Date of Admission: 3-1-23. -Diagnoses: -Per local hospital document dated 2-15-23 Disruptive Mood Dysregulation Disorder.</p>	V 113		

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V 113	<p>Continued From page 33</p> <ul style="list-style-type: none"> -Per application dated 3-1-23 ODD, Moderate; ADHD; PTSD. -No documentation of an identification face sheet. -No documentation of the screening and assessment. -No documentation of a treatment/habilitation or service plan. -No documentation of services provided. -No documentation of progress towards outcomes.. <p>Review on 4-12-23 of Client #4's record revealed:</p> <ul style="list-style-type: none"> -Age: 15 years old. -Date of Admission: 2-23-23. -Diagnoses: Not identified in the record. -No documentation of an identification face sheet. -No documentation of diagnoses. -No documentation of the screening and assessment. -No documentation of a treatment/habilitation or service plan. -No documentation of services provided. -No documentation of progress towards outcomes. <p>Review on 4-19-23 of Client #5's record revealed:</p> <ul style="list-style-type: none"> -Age: 16 years old. -Date of Admission: 4-10-23. -Diagnoses: Conduct Disorder. -No documentation of an identification face sheet. -No documentation of the screening and assessment. -No documentation of a treatment/habilitation or service plan. -No documentation of services provided. -No documentation of progress towards outcomes. <p>Review on 4-12-23 of FC #6's record revealed:</p> <ul style="list-style-type: none"> -Age: 15 years old. 	V 113		

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V 113	<p>Continued From page 34</p> <ul style="list-style-type: none"> -Date of Admission: 2-15-23. -Date of Discharge: Not identified in the record. -Diagnoses: Not identified in the record. -No documentation of an identification face sheet. -No documentation of diagnoses. -No documentation of the screening and assessment. -No documentation of a treatment/habilitation or service plan. -No documentation of services provided. -No documentation of progress towards outcomes. <p>Review on 4-12-23 of FC #7's record revealed:</p> <ul style="list-style-type: none"> -Age: 15 years old. -Date of Admission: 2-19-23. -Date of Discharge: Not identified in the record. -Diagnoses: Per application dated 2-19-23 ADHD; PTSD. -No documentation of an identification face sheet. -No documentation of a treatment/habilitation or service plan. -No documentation of services provided. -No documentation of progress towards outcomes. <p>Review on 4-13-23 of FC #8's record revealed:</p> <ul style="list-style-type: none"> -Age: 15 years old. -Date of Admission: 3-1-23. -Date of Discharge: 3-12-23. -Diagnoses: <ul style="list-style-type: none"> -Per Comprehensive Clinical Assessment addendum dated 9-26-22 Adjustment disorder; Anxiety; Oppositional Defiant Disorder. -Per application dated 3-1-23 no diagnoses listed. -No documentation of an identification face sheet. -No documentation of the screening and assessment. 	V 113		

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V 113	<p>Continued From page 35</p> <ul style="list-style-type: none"> -No documentation of a treatment/habilitation or service plan. -No documentation of services provided. -No documentation of progress towards outcomes. <p>Review on 4-17-23 of FC #9's recored revealed:</p> <ul style="list-style-type: none"> -Age: 16 years old. -Date of Admission: 2-9-23 (not in file. Obtained from client roster sheet receive from Licensee). -Date of Discharge: 2-28-23 (not in file. Obtained from client roster sheet). -Diagnoses: not present in file. -No documentation of an identification face sheet. -No diagnoses. -No documentation of the screening and assessment. -No documentation of a treatment/habilitation or service plan. -No documentation of services provided. -No documentation of progress towards outcomes. <p>Interview on 4-17-23 with the Qualified Professional/Program Director (QP/PD) revealed:</p> <ul style="list-style-type: none"> -Clients "do not have to have a diagnosis to be placed (admitted)..." -He was responsible for client records. <p>Interview on 4-19-23 with the Licensee revealed:</p> <p>" ...Listen this is not a plea. It took us a year and a half to open and the missteps we made of taking the wrong client in and we failed to do the basic things. The information is here, we have it but we haven't done a good job of keeping it in the files. We just didn't have it in the files."</p> <p>This deficiency is cross referenced into 10A NCAC 27E .0101 Least Restrictive Alternative (V513) for a Type A1 rule violation and must be</p>	V 113		

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V 113	Continued From page 36 corrected within 23 days.	V 113		
V 115	<p>27G .0208 Client Services</p> <p>10A NCAC 27G .0208 CLIENT SERVICES</p> <p>(a) Facilities that provide activities for clients shall assure that:</p> <p>(1) space and supervision is provided to ensure the safety and welfare of the clients;</p> <p>(2) activities are suitable for the ages, interests, and treatment/habilitation needs of the clients served; and</p> <p>(3) clients participate in planning or determining activities.</p> <p>(h) Facilities or programs designated or described in these Rules as "24-hour" shall make services available 24 hours a day, every day in the year, unless otherwise specified in the rule.</p> <p>(c) Facilities that serve or prepare meals for clients shall ensure that the meals are nutritious.</p> <p>(d) When clients who have a physical handicap are transported, the vehicle shall be equipped with secure adaptive equipment.</p> <p>(e) When two or more preschool children who require special assistance with boarding or riding in a vehicle are transported in the same vehicle, there shall be one adult, other than the driver, to assist in supervision of the children.</p> <p>This Rule is not met as evidenced by: Based on record reviews, observations and interviews, the facility failed to provide supervision</p>	V 115		

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V 115	<p>Continued From page 37</p> <p>to ensure the safety and welfare of the clients affecting 5 of 5 current clients (Client #1-#5) and 2 of 4 Former Clients (FC#6 and FC #7). The findings are:</p> <p>Review on 4-12-23 of Client #1's record revealed: -16 years old. -Date of admission 2-24-23. -Diagnosis: Attention Deficit Hyperactivity Disorder (ADHD); Disruptive Mood Dysregulation; Post Traumatic Stress Disorder (PTSD); Conduct Disorder; Unspecified Personality Disorder. -No evidence of admission screening.</p> <p>Review on 4-12-23 of Client #2's record revealed: -Age: 16. -Date of Admission: 2-21-23. -Diagnoses: Per local hospital discharge summary dated 2-21-23 Bipolar Disorder, Rare Mixed with Psychotic Effects; PTSD; Rule Out (R/O) ADHD; Oppositional Defiant Disorder (ODD); Cluster B Personality Traits. -No evidence of admission screening.</p> <p>Review on 4-12-23 of Client #3's record revealed: -Age: 12. -Date of Admission: 3-1-23. -Diagnoses: -Per local hospital document dated 2-15-23 Disruptive Mood Dysregulation Disorder. -Per application dated 3-1-23 ODD, Moderate; ADHD; PTSD. -No evidence of admission screening.</p> <p>Review on 4-12-23 of Client #4's record revealed: -Age: 15. -Date of Admission: 2-23-23. -Diagnoses: Not identified in the record. -Admission application dated 2-23-23 "Client wants to work on attitude and anger."</p>	V 115		

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V 115	<p>Continued From page 38</p> <p>Review on 4-19-23 of Client #5's record revealed: -Age: 16. -Date of Admission: 4-10-23. -Diagnoses: Conduct Disorder. -No evidence of an admission screening. -Comprehensive Clinical Assessment (CCA) dated 4-10-23 and faxed to the provider on 4-12-23 (per fax transmittal cover sheet by legal guardian) indicated a history of "suicidal remarks, self-harm and aggressive behaviors...when she feels her independence is threatened, she will either lash out physically or run away...Due to client behaviors including elopement, her team has had difficulty locating long term placement...Client has a significant trauma history including physical abuse, sexual abuse and reportedly human trafficking. Client is also currently on probation the Juvenile Justice. Client takes minimal responsibility for her choices and has shown little insight into her choices and related concerns for her safety...She continues to be at risk unless placed under close 24/7 supervision given her frequent elopement and history of trafficking. Placement at a PRTF (Psychiatric Residential Treatment Facility)...DJJ (Department of Juvenile Justice) documentation indicates that client has run away numerous times and has been passed around for sex by adult men while she was on the run ..."</p> <p>Review on 4-12-23 of FC #6's record revealed: -Age: 15. -Date of Admission: 2-15-23. -Date of Discharge: Not identified in the record. -Diagnoses: Not identified in the record. -Admission application dated 2-15-23 indicated "Expected stay is 90 days. Needs to follow up with a medication management appointment within the next two weeks...Youth has three</p>	V 115		

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V 115	<p>Continued From page 39</p> <p>weeks of medication upon arriving at placement."</p> <p>Review on 4-12-23 of FC #7's record revealed: -Age: 15. -Date of Admission: 2-19-23. -Date of Discharge: Not identified in the record. -Diagnoses: Per application dated 2-19-23 ADHD; PTSD. -Admission application dated 2-19-23 indicated "Details relative to placement. [FC#7] needs placement long term, placement disrupted since 1/16 however been in fictive kinship placement. There is a question about aggressive behaviors."</p> <p>Review on 4-13-23 of an undated document titled "Pinnacle Therapeutic Services Behavior Support and Management Philosophy and Procedures" in personnel files revealed: -"...Ensure that the safety and well-being of the child and others is guaranteed, particularly during times when the child may be temporarily out of control..."</p> <p>Review on 4-13-23 of the facility's internal incident reports revealed: -2-24-23 at 8:45 pm "...[Client #4] stated on 2-22-23 one of her male house peers (not identified in the report) touched her without her consent while sitting in the living room and it made her uncomfortable. [Client #4] informed her peer not to touch her in that manner. Then [Client #4] proceeded to say the same peer asked her to enter his bedroom and she did. [Client #4] completed the conversation by saying they had intercourse while she was in his bedroom without her consent...[Client #4] stated this incident occurred in the middle of the day while staff were downstairs in the office. [Client #4] informed the Program Manager (Qualified Professional/Program Director(QP/PD)) that she</p>	V 115		

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V 115	<p>Continued From page 40</p> <p>does not want to be at Pinnacle Therapeutic Services because she does not feel safe. [Client #4] stated 'she would do whatever it takes for her to be removed from Pinnacle Therapeutic Services tonight.' [Client #4] stated she would hurt herself if she had to remain at the house tonight. [Client #4] grabbed a pair of scissors from the staff's desk and stated, 'If I start self-harming will they come and get me then.'" Client #4 was transported to the emergency room.</p> <p>3-30-23 at 6:30 pm " ...As staff (QP/PD) stood at the top of the stairs [FC #6] came out of his bedroom cussing and threaten to kick staff a*s if I (QP/PD) did not go back downstairs. [FC #6] approached and pushed staff (QP/PD) then started pointing his finger in staff 's (QP/PD's) face making contact, while making statements that he (FC #6) was going to kick staff's (QP/PD's) a*s because staff (QP/PD) feared him. Staff (QP/PD) requested [FC #6] to stop and return to his bedroom ... [FC #6] continues to demonstrate aggressive behavior by pushing staff (QP/PD) for the second time, but with more aggression. Staff (QP/PD) started falling down the stairs after the second push from [FC #6]. The staff's (QP/PD's) natural reaction was to grab something to prevent me (QP/PD) from falling from the top of the stairs to the bottom. Staff (QP/PD) grabbed [FC #6] and both of us went falling down the stairs. Once we reached the bottom of the stairs [FC #6] continued to assault staff (QP/PD). Staff (QP/PD) extended his right arm and placed it on [FC #6] chest/neck area to prevent him from grabbing me (QP/PD). Another youth (Client #2) intervned by grabbing [FC #6] to help de-escalate the situation ..."</p> <p>-4-2-23 at 5:45 pm " ... [Client #4] was trying to ...harm to peers/staff with knife, broken glass. Client keep trying to get more objects knives, ink</p>	V 115		

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V 115	<p>Continued From page 41</p> <p>pen, glass ...Client then came closer to me (Staff #1) with glass broken from the window another client broke ...the prior day ...client had gotten her hand on 2 knives [law enforcement officer (LEO)] motioned me back to retrieve and put the knives in safe area ..."</p> <p>-4-7-23 at 3:40 pm " ...Staff was downstairs. Staff heard a loud noise with glass breaking. Staff went upstairs to find clients tossing over a lamp. Glass still visible with toxins in it on the floor. Broke prior to client [FC #7] breaking glass for a whole hr (hour) on 4-6-23 ...staff tried to move broken lamp. Client [FC #7] grab staff and told her 'get out' but it was unsafe to plug up as a fire hazard. Client refuse meds (medications) everyday ...client ...said that she would not be staying @ this xxxx cussing. Left, been AWOL (absence without leave) ever since ..."</p> <p>Review on 4-19-23 of the Local Police Department Incident/Investigation Reports dated 3-9-23 to 4-18-23 revealed:</p> <p>-3-9-23 at 9:33 pm law enforcement responded "for a report of male juveniles involved in a physical altercation...[FS #12] stated that juveniles [Client #2] and [FC #6] had been involved in a verbal altercation that became physical. [FS #12] stated that she observed [FC #6] strike [Client #2] first and then had to pull the two apart. [Local County Emergency Medical Services (EMS)] arrived and checked both juveniles for injuries. Neither juvenile was transported and EMS cleared with patient refusal...[FC #6's] signs of physical injury consisted of a small abrasion on the knuckles of his left hand. [Staff #1] stated that [FC #6's] nose was 'swollen' and had 'redness' on the right side of his face. [Staff #1] stated...that she would make arrangements with the owner of business (licensee) to have [FC #6] removed from the</p>	V 115		

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V 115	<p>Continued From page 42</p> <p>facility on 3-10-23." On 3-14-23 at 9:38 am law enforcement officer (LEO) made a follow up (visit) to Pinnacle Therapeutic Services in reference to the physical altercation and spoke to Former Staff (FS) #12. LEO "asked [FS #12] if she had made contact with [FC #6's] social worker to inquire about his removal from the facility. [FS #12] stated that she had not made contact...Juvenile petitions for assault were obtained for both [Client #2] and [FC #6]..."</p> <p>-3-11-23 at 1:57 pm law enforcement responded "in reference to a fight between 2 juveniles...[Staff #8] stated that [FC #6 (male)] and [FC #8 (female)] engaged in a physical fight inside of the residence...[Staff #8] stated that [FC #6] and [FC #8] were arguing over [FC #6's] gang affiliation...the argument escalated into a physical fight where both [FC #6] and [FC #8] struck each other...I (LEO) then spoke with [FS #12]...[FS #12's] statement was consistent with [Staff #8's]. The [local police department] has been to this residence on several occasions for [FC #6] starting fights at this location with other residents...[FS #12] stated that she will begin processes to have [FC #6] removed from the home..."</p> <p>-3-14-23 at 1:55 pm law enforcement responded "in reference to a report of disorderly conduct. While en route [local police department communications] advised that...a juvenile patient of the facility was attempting to steal a vehicle. Upon arrival I (LEO) observed...[Client #3] sitting in the driver's seat of a blue in color 2023 [Sport Utility Vehicle] ...The vehicle was running and [Client #3] was smoking a cigarette...[LEO] positioned his marked patrol vehicle behind the [SUV] so as to prevent [Client #3] from leaving with the vehicle...also placed...stop sticks under the [SUV] rear tires ...[FS #12] stated [Client #3] had threatened her inside the facility with a pair of</p>	V 115		

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V 115	<p>Continued From page 43</p> <p>scissors. [FS #12] described the threats as [Client #3] brandishing the scissors at her and making statements to cut her...[Client #3] also used the scissors to damage a desk inside the office of the facility. [FS #12] stated the incident may have stemmed from [Client #3] refusing to take her medication for the day ...I (LEO) approached [Client #3] still seated in the driver's seat of the still running [SUV]. [Client #3] was attempting to light a cigarette and refused to exit the vehicle..." Client #3 eventually exited the vehicle and "...was placed into handcuffs...[Client #3] began screaming and cursing...used her left leg to kick at officers. [Client #3] kicked me (LEO) in the shin...I (LEO) then entered the facility to observe the damage to the office...heavy scratches to an L-shaped wooden office desk...an electric pencil sharpener that appeared to have been thrown from the desk. The plastic shroud to the electric pencil sharpener had been completely shattered...[LEO] then placed [Client #3] into his patrol vehicle and transported her to [local police department]...While speaking with [Client #3], she stated that she had a vape on her person. [Client #3] removed the vape from her chest area and placed it onto the table...signed petitions and copy of report placed into juvenile justice box..."</p> <p>-4-2-23 at 5:59 pm law enforcement responded "in reference to a suicidal subject (Client #4)...the reporting party, [Staff #1] ...advised that juveniles inside were in a heated verbal altercation and that one of the juveniles [Client #4] had a piece of glass and medicine threatening suicide and to harm others. I (LEO) entered the residence and observed [Client #4] and another juvenile (not identified in report) in a heated argument, I (LEO) separated the juveniles and took [Client #4] into a room to calm her down...[Client #4] stated that she was being bullied by another girl in the home and that she was tired of hearing it. [Client #4]</p>	V 115		

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V 115	<p>Continued From page 44</p> <p>stated that she did have a piece of glass in her pocket, so I removed the glass and frisked [Client #4] for other weapons. [Client #4] stated to me (LEO) that she was not suicidal and did not want to harm anyone. While (LEO) still at the residence, [Client #4] continued to make threats towards the other juveniles in the home. [Staff #1] responded to [local police department] for IVC (involuntary commitment) paperwork on [Client #4] due to her not taking her medication and threatening to stab and beat up other juveniles. I (LEO) secured [Client #4] and transported her to [local hospital]..."</p> <p>-4-7-23 at 11:55 pm law enforcement responded "in reference to serving involuntary commitment papers. When I (LEO) arrived I spoke with [QP/PD] who stated that he had taken out the involuntary commitment papers on [FC #7]. [QP/PD] stated that [FC #7] was fighting with roommates and breaking glass around her bedroom. [QP/PD] then stated that [FC #7] had left the residence and that he needed to report her as a runaway. [QP/PD] stated that [FC #7]...discovered that [QP/PD] was planning on submitting involuntary commitment papers on her. [QP/PD] advised that she then became irate, and she walked out the front door at approximately 2100 hours (9:00 pm) ..I (LEO) checked the area but was unable to locate [FC #7]..."</p> <p>-4-10-23 at 10:13 pm law enforcement responded to Pinnacle Therapeutic Services "in reference to a runaway. Upon arrival, I (LEO) located the runaway [Client #3]...walking in the roadway in front of Pinnacle Therapeutic Services...[Client #3] ...she advised she didn't want to be in the home. As I (LEO) was speaking with [Client #3], the [QP/PD], stepped outside. Once [Client #3] saw [QP/PD], she became irate and upset and threw her slushy (drink) at [QP/PD]. [Client #3]</p>	V 115		

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V 115	<p>Continued From page 45</p> <p>stated 'That's for choking me.' [Client #3] advised [QP/PD] had choked her earlier ...[QP/PD] advised he ...was not going to allow her (Client #3) back in the house..."</p> <p>-4-11-23 at 1:03 pm law enforcement responded "in reference to a juvenile (Client #4) acting disorderly. Upon my (LEO) arrival...[Client #4] at the time was attempting to use a screw driver to disable a door lock to the office. I (LEO) took the screw driver from [Client #4] for safety reasons... [Client #4] advised that she was upset because [Staff #1] had made her cry earlier...that [Staff #1] yelled at her...then shoved her...[Client #4] additionally advised that she no longer wished to remain at the facility...[Staff #1] advised that [Client #4] was inside of her (Staff #1's) office even though no juveniles are permitted to be inside of the office without an adult present... [Staff #1] advised that [Client #4] would not move so that she (Staff #1) could walk to her desk. [Staff #1] advised that she squeezed past [Client #4] and [Client #4] stated for [Staff #1] not to put her hands on her...a short time later [Client #4] poured water all over [Staff #1's] desk to include her (Staff #1's) office computer..."</p> <p>-4-12-23 at 5:02 pm law enforcement responded "in reference to a civil disturbance. Upon arrival...14 year old, [Client #4] advised that she called (LEO) because she did not want to stay at the facility anymore. [Client #4] advised that the staff did not take care of their (clients) needs. [Client #4] advised that staff had allegedly attacked one of the other children in the home at an earlier incident. [Client #4] advised that she was suppose to be removed from the home to be relocated...[QP/Program Director] advised that he was going to try and seek IVC paperwork on [Client #4]...[Client #4] continued to tell me (LEO) that she did not want to be at the facility and that she did not want to stay there another night.</p>	V 115		

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V 115	<p>Continued From page 46</p> <p>[Client #4] continually stated to officers that she was just going to runaway as soon as we (LEO) left...[Client #4] stated she was going to damage property in an attempt to get arrested to be taken to 'juvy' (juvenile detention)...[Client #4] picked up a rock to throw at an employees vehicle. I (LEO) was able to stop [Client #4] from attempting to damage any property and block her attempts to pick up several bricks laying around the property...I (LEO) spoke with the owner (licensee) of the facility who advised that they had spent a large sum of money to open the facility ...that when he selected the first kids to stay in the home, he did not look into the backgrounds of the children to ensure they (staff) could provide adequate care. The owner (licensee) advised that he just picked the first several children to allow the facility to get money. The owner (licensee) advised he was attempting to get several of the children rehomed as their facility was not at the level needed for those children. The owner (licensee) advised that he was going to try and get an IVC on [Client #4]...During the conversation with [Client #4], none of the staff for the facility attempted to speak with [Client #4] and attempt to keep her at the residence. Majority of the staff remained inside of the building locked in the office. [Client #4] walked to area of [local church]...across the road from the facility. Officers (LEO) attempted to get [Client #4] to return to the residence, but she refused. None of the staff was present to speak with [Client #4]. I (LEO) advised [QP/PD] that [Client #4] was ultimately the facilities responsibility and that she was in their care. I (LEO) advised [QP/PD] it would be up to them (facility) to keep her (Client #4) at the residence. [QP/PD] advised 'as long as I can see her (Client #4).' When officers left the scene, [Client #4] was still in the area of [local church] and none of the staff were there</p>	V 115		

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V 115	<p>Continued From page 47</p> <p>attempting to get her to return to the facility. The [local police department] has had multiple calls for service for similar situations in the short time that the facility has been active with multiple children being reported as runaways from the facility. [Local police department lieutenant] has spoken with the facility in reference to these issues..."</p> <p>-4-12-23 at 8:26 pm law enforcement responded "in reference to serving involuntary commitment papers...I (LEO) spoke with [QP/PD] who stated... [Client #4] had been irate and acting violent recently, so he attempted to take out involuntary commitment papers out on her. When I (LEO) arrived at the facility [QP/PD] stated that [Client #4] had not returned to the facility...[QP/PD] stated that he last saw her go inside of the [local retail store]. [LEO] checked the area but was unable to locate [Client #4]...There are no locations that [Client #4] would go to or stay at in her file at the facility...On 4-13-23 I (LEO) was advised by [local police department communication center] that [Client #4] was located at her Mother's residence in [another city approximately 50 miles away]..."</p> <p>-4-14-23 at 3:39 am "...Caller (FC #7) requesting a call by phone...she had several items stolen from this location (Pinnacle Therapeutic Services)..."</p> <p>-4-18-23 at 10:16 pm law enforcement responded "in reference to a runaway. Upon arrival I was met by [Staff #2] who advised [Client #5] ran away. [Staff #2] stated that at approximately 1945 hours (7:45 pm) [Client #5] asked to go to the gas station across the street. [Staff #2] stated that she told [Client #5] to sign out in the book and be back in 10 mins (minutes). [Staff #2] stated that [Client #5] never returned...I (LEO) canvassed the area on foot and via my patrol vehicle but did not locate [Client #5] in the</p>	V 115		

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V 115	<p>Continued From page 48</p> <p>area...On 4-19-23 at approximately 0044 hours (12:44 am) I (LEO) responded back to [Pinnacle Therapeutic Services] in reference to [Client #5] returning..."</p> <p>Review on 4-12-23 of the Local Police Department Computer-Aided Dispatch (CAD) report dated 4-12-23 revealed:</p> <ul style="list-style-type: none"> -19 law enforcement calls for service to Pinnacle Therapeutic Services from 2/24/23 through 4/11/23. -Calls in addition to the above referenced Local Police Department Incident/Investigation Reports included the following: <ul style="list-style-type: none"> -2-24-23 at 10:24 pm "Assist Another Agency ...Have a female subject (not identified in CAD report) feeling suicidal..." -3-4-23 at 5:23 pm "Civil Disturbance...2nd call this location ...altercation between 15 y/o (year old) and 16 y/o (individuals not identified in CAD report)...they are fighting..." -3-6-23 at 8:35 pm "Civil Disturbance...caller states one of the youth has ran away from this location. 16 y/o female, wearing wht (white) boxer briefs and wht tank top...Female's name [FC #7]..." -3-15-23 at 2:00 pm "Health Check...Resident (Client #4) wants to move out. Stated social worker and staff won't help her..." -3-20-23 at 5:26 pm "Damage to Property... [FC #6] picking up wooden pavers from PVA (public vehicular area) and was hitting staff's vehicle..." -3-22-23 at 12:17 am "Property Check (no details provided)." -3-29-23 at 7:23 pm "911 hang up...Female (not identified in CAD report) stated they were fighting and hung up...Caller (not identified in CAD report) advised that they called because one of the juveniles (not identified in CAD report) was 	V 115		

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V 115	<p>Continued From page 49</p> <p>attempting to fight with the staff..."</p> <p>-3-31-23 at 3:41 pm "Involuntary Comm (Commitment/IVC)...[Client #1]...is combative and refusing to take her medicine. Paperwork in magistrate office..."</p> <p>Review on 4-14-23 of an email dated 4-14-23 to a Division of Health Service Regulation (DHSR) Surveyor from a Lieutenant with the Local Police Department revealed:</p> <ul style="list-style-type: none"> -The local police department completed juvenile petitions on the following clients: -Client #2 for Simple Assault. -Client #3 for Larceny of a Motor Vehicle, Assault on a Government Official, Communicating Threats, and Damage to Property. -FC #6 for two separate incidents of Simple Assault. <p>Review on 4-18-23 of local police department body camera video footage dated 4-10-23 and time stamped 10:24 pm to 11:07 pm revealed:</p> <ul style="list-style-type: none"> -At 10:25 pm Local law enforcement arrived at Pinnacle Therapeutic Services. -Client #3 was locked out of the facility for at least 40 minutes from 10:25 pm through 11:07 pm. -There was no evidence of any facility staff being present outside to monitor Client #3 during the entirety of the body camera footage. <p>Observation on 4-17-23 at 11:00 am of the roadway directly outside of the facility revealed:</p> <ul style="list-style-type: none"> -The facility was located on a 5-lane road -There were two lanes of traffic heading in one direction, two lanes of traffic heading in another direction, and a center turn lane. -The posted speed limit was 45 miles per hour. -There were no sidewalks nor crosswalks on either side of the road in the vicinity of the facility. 	V 115		

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V 115	<p>Continued From page 50</p> <p>Observation on 4-17-23 at 2:45 pm of the roadway in front of the local retail store revealed: -Located approximately 0.4 miles from the facility. -4-lane road with two lanes of traffic heading in one direction and two lanes of traffic heading in another direction. -The posted speed limit was 45 miles per hour.</p> <p>Observation and interview on 4-12-23 at 2:48 pm with Staff #1 revealed: -Staff #1 came into the conference room and stated, "I'm locking y'all (DHSR surveyors) in here out of concern for your safety. [Client #4] is showing out and just tossed water all over the computer in the office and broke a pair of scissors." Staff #1 locked both doors to the conference room and showed surveyors one half of a pair of scissors and stated, "[Client #4] is outside with [Licensee] right now and she has the other half." DHSR surveyors could see through a set of French doors that the Licensee and Client #4 were outside of the facility on the front porch. No other staff were present outside with the Licensee and Client #4. Staff #1 informed DHSR surveyors that law enforcement was being called.</p> <p>Interview on 4-11-23 with Client #1 revealed: -"...They (facility staff) filled out IVC paperwork on me for some stuff that I did a month ago, so they IVC me saying I was a danger to self and others because I struck a staff member in the face with a laptop, but that was a month ago. I wasn't taking my meds (medications) and they sent me to the hospital...I've been refusing all of them (medications) for a good 3 weeks but I'm back taking them now..." -"...[QP/PD] somewhat put hands on, it was like you know, I'm gonna say this, I'm not gonna snitch, it was seeing anger because I know what</p>	V 115		

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V 115	<p>Continued From page 51</p> <p>it feels like to get beat on, but the boy (FC #6) that was here before had anger problems and all I heard was they (QP/PD) and FC #6 were both in each other's face and then I heard duke, duke, duke and then the boy (FC #6) was down on his face and up against the wall and all like that..."</p> <p>"...this is not a type of facility where it's a respite home, so they (staff) don't deal with types of behaviors and can't get the person or situation under control and you're kind of stuck in a loop here and they (police) have been here quite a few times...they (staff) aren't really qualified to deal with behaviors, so all you can do is call the cops...They do tell the social workers that from day one, that they (staff) are just giving us somewhere to stay until they find placement..."</p> <p>Interview on 4-11-23 with Client #2 revealed: -"This is a facility that if kids want to act up, they (staff) can't put their hands on them, so they (staff) call the police..."</p> <p>-He had been involved in a physical altercation with FC #6 and staff called law enforcement. -He observed FC #6 try to push the QP/PD down the stairs and the QP/PD had to defend himself.</p> <p>Interview on 4-14-23 with Client #2's guardian revealed: -" ...a female resident (Client) went into his (Client #2) room and they engaged sexually ...My supervisor asked 'why don't staff sit in the hallway and be proactive, preventative measures' but there was nothing done ...It was reported to us that it was consensual."</p> <p>" ...I haven't known the police to be there (facility) at all. That's news to me ...He (Client #2) hasn't made me aware of any of that with the police being there. I have no knowledge whatsoever of law enforcement being there ...I would have been very concerned if he (Client #2) was having to</p>	V 115		

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V 115	<p>Continued From page 52</p> <p>engage with law enforcement. That would be very concerning."</p> <p>Interview on 4-11-23 with Client #3 revealed: -"...well, there was this kid named [FC #6] and [QP/PD] choked him and pushed him against the wall and yesterday, [QP/PD] choked me. I think he (QP/PD) is unfit, and they (staff) don't have any experience and they (Licensee) hire new people all the time and they are very new. Like yesterday, [Staff #2] slammed a door on the police officer. This place is unfit for kids. The police was telling her that I was in their care, and she slammed the door and locked the door and the police said if something happened to me that I was in the care of this place. I was outside and I only had pants on and no jacket on. I was outside for 20 minutes. I had to bang on windows and the door upstairs and my peers (clients) let me in .." -On 4-10-23 after being let back into the facility, staff locked themselves in the office. -"...Police are here a lot because the staff calls them, because the staff don't know where to take us, because the hospital or the police is their only options and resources. When clients get upset, that's the only thing that they do is call the police, call the police. They don't do anything else ..." -"...There are people here that have weed (marijuana) and vapes because they don't do searches here .." -"...I stole a car...I grabbed the keys to the car ..Staff leave keys around, and doors unlocked, and glass everywhere, there was glass upstairs and I have been cut on my feet from glasses and plates being broken..." -"...They (staff) send clients to the hospital because they don't know where to take them, even if a client is not self-harming, or a danger to anyone else ..This place is unfit for kids."</p>	V 115		

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V 115	<p>Continued From page 53</p> <p>Interviews on 4-11-23 and 4-12-23 with Client #4 revealed:</p> <p>-She had been hospitalized twice since being admitted to the facility.</p> <p>-The first hospitalization "was because I didn't feel safe. That was my first, or second day. I just didn't feel right. It was peer (client) related. I told [QP/PD]."</p> <p>-"...[QP/PD had one of the boys (FC #6) that is no longer here by his neck on the wall and on the ground by the stairwell by his neck. This was like 2 -3 weeks ago...I saw the [QP/PD] choke [FC #6]..."</p> <p>-"...I want to leave today. I am not staying another day or night here (Pinnacle Therapeutic Services) because of the way staff is treating me. My peers (clients) would pick on me because of my size and staff wouldn't do anything when I would tell them. They would pick on me because of my size and weight..."</p> <p>-"...[Staff #1] tries to make us (clients) scared of her. Like when we have behaviors. She is like don't do that. I had a piece of glass that I took from the back door and pointed at her, and she pointed a pen at me and said she would have stabbed me..."</p> <p>-"...I don't want to be here. I don't feel comfortable being here ...It's just horrible here. I would rate this place a zero. Sometimes the staff allow the kids to go in my room and get my stuff. They (staff) don't lock the door ...People go in my room and take my stuff...Staff sometimes they yell, sometimes they yell at us ...This is not a safe environment. People won't believe me because there is no cameras installed except for in the kitchen. I got pushed by [Staff #1] yesterday in the office, no cameras..."</p> <p>-Law enforcement came to the facility "...a lot ...They came here last night, for another girl (Client #3)...They (staff) wouldn't let her in. She</p>	V 115		

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V 115	<p>Continued From page 54</p> <p>was throwing stuff, and tried to run away ..."</p> <p>Interview on 4-11-23 with Client #5 revealed: -She had seen the police at the facility on two occasions since being admitted to the facility. -She had been admitted to the facility for only one day.</p> <p>Efforts were made on 4-17-23 to interview FC #6 but were unsuccessful.</p> <p>Efforts were made on 4-14-23 and 4-17-23 to interview FC #6's guardian but were unsuccessful.</p> <p>Interview on 4-13-23 with Staff #1 revealed: -"...[Client #2] helps de-escalate any situation for whatever is going on in the house..." -"[Client #4] is AWOL (absent without leave). Last I heard, she was in the police officer's custody. She threw stuff at my car after y'all (DHSR Surveyors) left yesterday...she was damaging people's property. I don't know where she is..." -Law enforcement was at the facility twice this week. -"...[Client #4] busted in the office and said she wanted medicine and tried to grab the med (medication) drawer on April 12th and it was locked...She (Client #4) pulled out some (night time cough medication) and a piece of glass. She went in there and pulled it out of the window which had broken the prior day. She got me in the corner. She pulled the drawer opened and popped the top lock and she said 'don't touch me' and she got the (night time cough medication) and had glass, so I called 911. They (911 dispatch) sent somebody and right when the cops showed up she threw the (night time cough medication) all over the floor and the cops came in and me and him (LEO) switched places and</p>	V 115		

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V 115	<p>Continued From page 55</p> <p>other staff were de-escalating the other clients when I tried to go to the magistrates office and the cop called me back because she (Client #4) grabbed 2 knives and I had to have her IVC'd...They (clients) were body shaming her (Client #4). I think it's a new thing. She (Client #4) said I touched her and that I hit her, but all I did was walk past her. She'll be grabbing scissors and stuff like that, so I just move myself out of the area to a safe place and then I let the police handle it because I am not going to be hurt. We (staff) can't touch them (clients), and they know that. She went and called the police first and then went to the office to stand in front of me and I squeezed by her to get out of harms way and she tried to body block me and she got really upset..."</p> <p>"...we were upstairs trying to de-escalate and [Client #3] called 911 because she knew what to do. [FC #6] tried to push staff (QP/PD) down the stairs and took his body and tried to shove him down...[QP/PD] put both his hands out saying let me go...[FC #6] said he was 'trying to get' [QP/PD] since the day he got here, so we had to de-escalate that..."</p> <p>"I don't know nothing" about clients having sexual intercourse.</p> <p>"...anybody around [Client #3] got to keep their guards up because she picks up heavy items. She (Client #3) tried to hit her roommate over the head with a fire extinguisher and yesterday she had a fire extinguisher she grabbed off the rack and took it outside but when I told her to bring it back she handed it to me..."</p> <p>Interviews on 4-18-23 and 4-19-23 with Staff #2 revealed:</p> <p>-Clients can go outside unsupervised. "They have to sign out when they leave the premises and take the company phone if they leave in case the police or anything happens. They go to the</p>	V 115		

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V 115	<p>Continued From page 56</p> <p>convenience store. We look at notes to see which ones are allowed to leave and which ones aren't. Some have behaviors ..."</p> <p>-On 4-10-23, Client #3 was "...throwing stuff from upstairs...glass everywhere, fan thrown down, a table thrown down and it broke and she was just doing a whole lot and we (staff) just cleaned the room for the new tenant...[QP/PD] went upstairs and [Staff #4] went upstairs...went to find out what the problem was...and next thing I was in the office and she (client #3) packed her stuff and walked out the door and it was night time and she was cussing...We (staff) kept smelling something burning and come to find out the old client had marijuana or something. She (Client #3) was smoking something up there by herself...and [Staff #1] could smell it...and that's why she was acting out because she was getting high off whatever the other client left there. [Client #3] was sneaking stuff in the house...She was flicking a lighter [Staff #4] said 'She has a lighter' and I said...I doubt she will burn the house down."</p> <p>-The police were called for AWOL and she (Client #3) was out there talking to the police.</p> <p>-Incident on 4-18-23 with Client #5, "She (Client #5) wanted to go to the store and I told her we (staff) were changing shifts the first time but she left at 5pm and didn't return until 6:30 pm and I said you shouldn't go to the store because you didn't return last time. She (Client #5) wanted to walk to the convenient store and [Staff #3] said 'you can go across the street and I'll watch you' and she went across the street and just disappeared and we waited until 7:45 pm or 8 pm and called (law enforcement). She (Client #5) signed the book (visitor's log) to go out...and she was walking on the grass and me and [Staff #3] were looking out the window and I think somebody picked her up because she had a cell phone and we should have took the cell phone</p>	V 115		

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V 115	<p>Continued From page 57</p> <p>the first time. She didn't come back until 8:45 (pm) and we called her because it was dark outside and it went straight to voicemail and didn't even ring and she wasn't back before dark and we waited until 9:30 (pm) and we told [Licensee] we called and let him know she left to go to the store and we went there and found out she never went to the store and she is from [city the facility is in] so somebody probably came and picked her up because she knows people and then at 10:15 (pm) we called in a missing person and they (local law enforcement) arrived around 10:45 (pm) and then around shift change is at 12 and she came around 12:30 am...so I just let her in to the bathroom and when she came out she went to her room and I was like 'wait a minute why didn't you come back from the store' and she said she was just sitting out back but she wasn't sitting out back and I told her if she couldn't follow the rules she would get kicked out of the house. She got in the shower at 12:35 am and you're not supposed to take showers at 12:30 (am) or 12:45 (am) and she was walking around the house, and she isn't supposed to do that stuff and she isn't following any of the rules and she has a problem with authority..."</p> <p>Interviews on 4-17-23 and 4-18-23 with FS #12 revealed: -"There was no rules or regulations set..." -Police were there "...at least once a week and one week while I was there twice. Average of 1-2 times per week for fights." -"She (Client #3) had a pair of scissors in her hand and threatened to stab me. They were a long pair of 8 inch scissors and I don't know where she got them from...I tried to talk to her to get her calmed down and she said leave me the 'f' (f**k) alone or she would stab me...She was sitting across from my desk in one of the chairs</p>	V 115		

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V 115	<p>Continued From page 58</p> <p>and got up and started stabbing my desk with the scissors that she had. She started scraping the desk with the scissors and tossing things around. I stepped out to speak with the Social Worker and my car keys were laying there...I didn't see her (Client #3) pick up the keys. She went outside and I followed her. She went toward my car, and I thought she was going to destroy my car with the scissors...she (Client #3) got inside my car and clicked it locked so I called [local law enforcement] and (I) was still on the other phone with her Social Worker. The officer pulled up and blocked the car in. She started my car several times off and on. My car is push button and she couldn't figure out how to put it in gear...There was a total of 4 officers that came out there that day. They (law enforcement) had to put stop strips in front of the car in case she was able to pull forward in the car to prevent her from getting into the road..." Client #3 got out of the car. "...She (Client #3) was handcuffed by the police, and they could take her in for threatening me and getting into my car without permission. She was taken to the station, and she came back about 1 hour later..."</p> <p>-Staff were not expected to stay upstairs (in the vicinity of the client bedrooms).</p> <p>-Client #4 made a sexual allegation against Client #2.</p> <p>-"They (Licensee and QP/PD) really didn't say a specific timeline of doing bed checks until the allegation was made (of sexual intercourse) of [Client #2] and [Client #4] and then it was supposed to be every hour on the hour at night...that's when [QP/PD] started working third shift."</p> <p>-The Licensee also provided direct care. "...He also worked some third shifts as well."</p> <p>-"They (staff) allowed [Client #2] and [FC #7] to walk to the store or to [local retail store]. To my</p>	V 115		

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V 115	<p>Continued From page 59</p> <p>understanding that was without DSS (Department of Social Services) authorization to do that because that is a busy road in front of that house. It's a very busy road there. It's crazy through there all the time with vehicles."</p> <p>"-We are level zero respite and other than 2 kids that were level 1's [FC #7 and Client #2] and the rest of the kids were level 3 and up. We had 3 that was a top level of PRTF which was [Client #1, FC #6, and Client #3]. He (Licensee) took whatever he could take to get money coming in whenever we opened up. He told me that himself. That's the reason the cops were called so often and with the fights and escalation being so high for those kids is because we were operating outside of what we were trained for."</p> <p>"-...I decided that I needed to get out of there because of how it was being run. I told [QP/PD] I was at my wits end and something had to be done. I also told [Licensee]. They gave me paperwork for 3 other kids to look at to determine if they were appropriate for placement and none of them were appropriate for our level of placement."</p> <p>Interview on 4-17-23 with the QP/PD revealed: -He was responsible for providing oversight of the facility. -"One of the young ladies got upset and ended up knocking the glass out (of the back door)...It happened this week...It was when [Client #4] got a piece of glass and got committed so it was last week within the past 7 days." -Activities for clients, "It doesn't have anything specific. They do get leisure activities...I haven't had a daily activity instated into the house and how it's being operated. It's more person centered on activities that need to be accomplished throughout the day." -"...The legal guardians inform us about</p>	V 115		

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V 115	<p>Continued From page 60</p> <p>education, one individual has been out of school for 3 months (Client #2) but they didn't know he would be here for more than 30 days..."</p> <p>-"[Client #3 and Client #1] were upstairs arguing and I went up the stairs and got to the top of the stairs and started redirecting them and as I'm encouraging them to stop, [FC #6] came out of his bedroom and started yelling and pushed me and he pushed me down one step. I asked him to please stop touching me. All the kids (clients) came out of their rooms and gathered to see what was going on. I kept telling [FC#6] that this had nothing to do with him. He popped me in the head and pushed me and I felt like I was falling down the steps and my first reaction was to grab the first thing which was him (FC #6) and we both fell down the steps. We got up and I put my hands up to tell him to go the other way and he pushed me and the kids were yelling for [FC #6] to stop...People were thinking I choked him. He (FC #6) was the aggressor. If I wasn't on the steps I could have moved back. I had my arm extended and he was trying to grab me and we are no hands on and he was trying to grab me and I was repeating please go the other way, please go the other way. I never had my arms around him as if I was choking him.</p> <p>[Client #1] said, [QP/PD] you're choking him. I wasn't choking him. That's when [Client #2] said come on [FC #6] you need to stop what you're doing."</p> <p>-"She (Client #4) came on a Thursday ...Friday night at 8 pm I was giving [Client #4] her meds (medication) and she said I need to talk to you. She said she had intercourse with [Client #2] yesterday. I asked where was everybody at. She said staff was in the office, laundry room. She said [Client #2] had touched her and made her feel uncomfortable and she asked him not to touch her. Then he asked her if she would go in</p>	V 115		

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V 115	<p>Continued From page 61</p> <p>his bedroom. I asked her why she went into the bedroom since they aren't allowed in each other's rooms...she informed...that it was consensual and everything that happened was consensual."</p> <p>-"We don't have a policy or anything that we have to provide staff up (awake) at night. They just have to be present at the house but we put those things in place to provide a little more attention to the issue"</p> <p>-"The other day when y'all (DHSR surveyors) had been here [Client #4] left and went to [local retail store] and wasn't found until the next day at her grandma's house. She jumped in the car with some man and he took her from [city of facility] to [another county approximately 50 miles away]. She was finally picked up and sent to the hospital."</p> <p>-"Again with [Client #3], that night (4-10-23) during a room check. I was in the office and could smell something burning and I did rounds and went upstairs and knocked on the door and then she realized she was doing something she shouldn't be doing. She had candles lit. I blew them out and asked where the lighter was that she lit them with. She wouldn't turn it over to me so I took her laptop until she would give it (lighter) to me. ...She (Client #3) started throwing stuff all over her room and down the stairs. She packed a bag and stated I'm leaving this 'MF' (m****r f****r). She (Client #3) got outside and stood on the porch. I stood out there with her and she got on a bike and said I'm leaving. I said if you're going AWOL you can't leave on this bike. I put one hand in my pocket and turned to the side and I shouldn't have done that and she punched me. She then got two vacuum cleaner poles. She tried to hit me. I grabbed one with each hand and she yelled so staff could hear that 'you pushed me, you trying to choke me'. She went across to the store and the police came and she returned from</p>	V 115		
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V 115	<p>Continued From page 62</p> <p>the store and threw the 2 slushies (at me)." -During safety checks he did not find marijuana "just a blunt paper and the girls blamed it on [FC #7]. She did have a history of substance use."</p> <p>Interviews on 4-11-23, 4-13-23 and 4-19-23 with the Licensee revealed: -Acknowledged it had been a common issue with law enforcement coming to the facility. -"Their Lieutenant called and asked why they (law enforcement) are having to come out here (to the facility) quite a bit but the mix of clients we took are some PRTF kids...it's just the type of kids we have here but we look at CCAs now so we can look at it and see if we can handle it. This isn't the first time she (Client #4) has been in this type of situation. She was here only for 1 day and then was sent to a psychiatric unit at [local hospital]." -"We just opened and took the first 6 or 7 (clients)..." -He had not been "practicing" the client to staff ratio. -"No, we have not done a good job of doing it..." (following admission criteria) -"I think we have done an okay job (with activities for clients)...we had 3-4 PRTF kids..." -"It was for an incident between [QP/PD] and a discharged client (FC #6) from my understanding. I will say that you guys (DHSR surveyors) have looked at the discharged client's history and his stay while he was here and I think we did a decent job of documenting the physical of what he did while he was here like wanting to break windows and wanting to do bodily harm so when that happened I did ask what transpired ..." -He was aware of the sexual allegations made by Client #4 against Client #2. -"...I am not an employee, I just handle the business, you may have seen me talking to her (Client #4) yesterday; I don't do care."</p>	V 115		

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V 115	<p>Continued From page 63</p> <p>"...(I'm) here for strictly business and don't get involved in incidents and stuff going on here." -Was responsible for "...getting the right people in place...doing background checks."</p> <p>Review on 4-19-23 of a Plan of Protection (POP) signed and dated by the Licensee on 4-19-23 revealed: -What immediate action will the facility take to ensure the safety of the consumers in your care? "When a report of abuse, neglect, harm or exploitation is received, the Owner (Licensee)/QP (Qualified Professional/Program Director (QP/PD)/QA QI (Quality Assurance Quality Improvement) will make a prompt and thorough assessment, using investigative assessment process, to ascertain the facts of the case, including collecting information concerning the alleged consumer to have been abused or neglected. We will investigate the extent of the allegation, and the risk of overall harm to the consumer in order to determine whether the appropriate level has been set. When the report alleges serious neglect, the Owner (Licensee)/QP (QP/PD)/QA QI will immediately, but no later than 24 hours after receipt of the report, initiate the assessment.</p> <p>The reporting by Pinnacle Therapeutic to the Department of Health and Human Services (DHHS) of all allegations against staff as defined in G.S. (General Statute) 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the agency becoming aware of the allegation. The results of the agency's investigation shall be submitted to DHHS in accordance with G.S. 131E256(g). The MCO (Managed Care Organization) will be notified by the Owner (Licensee) in writing of any employee, intern, volunteer, or contractor who is under investigation for abuse and/or neglect.</p>	V 115		

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V 115	<p>Continued From page 64</p> <p>This will be done within 48 hours of learning of the investigation. If the Owner (Licensee) is under investigation for abuse and/or neglect, the QP (QP/PD)/QA QI will notify the MCO in writing within 48 hours of learning of the investigation. The agency shall update the MCO with any progress made in the investigation. Describe your plans to make sure the above happens.</p> <ul style="list-style-type: none"> -PTS (Pinnacle Therapeutic Services) will create an incident report log that will consist of Policy and Procedures for Incident reporting. -PTSS will retrain all staff members within the next 7 days on how to complete and report incident reports in a timely manner. -The Program Assistant will review all incident reports daily. -The Program Director (QP/PD) will follow up weekly to ensure incident reports are completed and submitted in a timely manner. -QA/QI review biweekly for the next 90 days to ensure all employees understand and can implement the expectation for completing all incident reports. -All staff will be retrained with incident reporting will meet DHHS/IRIS (North Carolina Incident Response Improvement System) standards." <p>Review on 4-19-23 of an amended POP signed and dated by the Licensee on 4-19-23 revealed: - What immediate action will the facility take to ensure the safety of the consumers in your care? "When a report of abuse, neglect, harm or exploitation is received, the Owner (Licensee)/QP (QP/PD)/QA QI will make a prompt and thorough assessment, using investigative assessment process, to ascertain the facts of the case, including collecting information concerning the alleged consumer to have been abused or</p>	V 115		

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V 115	<p>Continued From page 65</p> <p>neglected. We will investigate the extent of the allegation, and the risk of overall harm to the consumer in order to determine whether the appropriate level has been set. When the report alleges serious neglect, the Owner (Licensee) /QP (QP/PD)/QA QI will immediately, but no later than 24 hours after receipt of the report, initiate the assessment.</p> <p>The reporting by Pinnacle Therapeutic to the Department of Health and Human Services (DHHS) of all allegations against staff as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the agency becoming aware of the allegation. The results of the agency's investigation shall be submitted to DHHS in accordance with G.S. 131E256(g).</p> <p>The MCO will be notified by the Owner (Licensee) in writing of any employee, intern, volunteer, or contractor who is under investigation for abuse and/or neglect. This will be done within 48 hours of learning of the investigation. If the Owner (Licensee) is under investigation for abuse and/or neglect, the QP (QP/PD)/QA QI will notify the MCO in writing within 48 hours of learning of the investigation. The agency shall update the MCO with any progress made in the investigation. Describe your plans to make sure the above happens.</p> <ul style="list-style-type: none"> -PTS will create an incident report log that will consist of Policy and Procedures for Incident reporting.- -PTSS will retrain all staff members within the next 7 days on how to complete and report incident reports in a timely manner. -The Program Assistant will review all incident reports daily. -The Program Director (QP/PD) will follow up weekly to ensure incident reports are completed and submitted in a timely manner. 	V 115		

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V 115	<p>Continued From page 66</p> <ul style="list-style-type: none"> -QA/QI review biweekly for the next 90 days to ensure all employees understand and can implement the expectation for completing all incident reports. -All staff will be retrained with incident reporting will meet DHHS/IRIS standards. -We will review DHHS/.5100 (North Carolina administrative code for Community Respite Services for Individuals of all Disability Groups) supervision policy details with staff. -Supervision will be maintained weekly by QP (QP/PD). -Will perform routine bed checks for consumers (clients). -Created visitation sign in, sign-out log. -Safety concerns for clients will be addressed via client surveys biweekly." <p>This facility is licensed for community respite services. Clients served by the facility ranged in age from 12 to 16 years old. They had diagnoses including, but not limited to, Attention Deficit Hyperactivity Disorder, Disruptive Mood Dysregulation, Post Traumatic Stress Disorder, Conduct Disorder, Adjustment Disorder Anxiety, Unspecified Personality Disorder, Bipolar Disorder, Rare Mixed with Psychotic Effects, Oppositional Defiant Disorder and Cluster B Personality Traits. Client #5 had a history of suicidal comments, self-harm, and aggressive behaviors. She had a significant trauma history including physical and sexual abuse as well as reported human trafficking. Due to elopement risks and the history of trafficking, she was recommended for PRTF placement and required close 24/7 supervision. On 4-18-23 facility staff allowed Client #5 to leave the facility unsupervised to go to the store down the street. She didn't return and hours later, facility staff called local law enforcement to report a runaway.</p>	V 115		

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V 115	<p>Continued From page 67</p> <p>There have been at least 19 occasions in which law enforcement responded to the facility between the dates of 2-24-23 to 4-11-23, with at least 5 additional calls between 4-12-23 to 4-19-23. These calls were regarding multiple situations including but not limited to, suicidal behaviors, physical aggression, disorderly conduct, runaway behaviors, civil disturbance, and damage to property. Client #2, #3 and FC # 6 received criminal charges while at the facility which include simple assault, larceny of a motor vehicle, assault on a government official, communicating threats, and damage to property. The Licensee reported to law enforcement that when he selected the first clients to stay in the home, he did not assess the backgrounds of the children to ensure that staff could provide the required level of care and supervision to ensure client safety. On several occasions, staff would lock themselves inside the office of the facility and away from clients. Clients reported that staff are not capable of dealing with clients' behaviors. The facility is located on a busy 5 lane roadway, with no sidewalks, and a speed limit of 45 miles per hour. There have been multiple runaways from the facility and staff allowed clients to come and go from the facility unsupervised during day and night hours. The Licensee and QP/PD failed to ensure that facility staff were capable of providing safety and supervision of the clients in their care.</p> <p>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 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.</p>	V 115		

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V 118	<p>27G .0209 (C) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</p> <p>(c) Medication administration:</p> <p>(1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs.</p> <p>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.</p> <p>(3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications.</p> <p>(4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following:</p> <p>(A) client's name;</p> <p>(B) name, strength, and quantity of the drug;</p> <p>(C) instructions for administering the drug;</p> <p>(D) date and time the drug is administered; and</p> <p>(E) name or initials of person administering the drug.</p> <p>(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.</p> <p>This Rule is not met as evidenced by:</p>	V 118		

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V 118	<p>Continued From page 69</p> <p>Based on observations, record reviews and interviews, the facility failed to ensure medications were administered to clients only on the written order of a Physician affecting 4 of 5 current clients (Client #1, #3-#5) and 1 of 4 Former Clients (FC #7) and failed to ensure medications were administered only by persons trained by a registered nurse, pharmacist or other legally qualified person for 2 of 2 Former Staff (FS #12 and #13), and failed to keep MARs current affecting 5 of 5 current clients (Clients #1-#5) and 1 of 4 Former Clients (FC) #7). The findings are:</p> <p>Review on 4-13-23 of Former Staff #12's personnel record revealed: -No evidence of medication administration training.</p> <p>Review on 4-13-23 of Former Staff #13's personnel record revealed: -No evidence of medication administration training.</p> <p>Review on 4-12-23 of Client #1's record revealed: -Age: 16 years old. -Date of admission 2-24-23. -Diagnoses: Attention Deficit Hyperactivity Disorder (ADHD); Disruptive Mood Dysregulation Disorder; Post Traumatic Stress Disorder (PTSD); Conduct Disorder and Unspecified Personality Disorder. -No evidence of physician's orders for any medications.</p> <p>Observation on 4-12-23 at 12:10 pm of Client #1's Medications revealed: -Loratadine (allergies) 10 milligrams (mg) 1 by mouth daily in the morning dispensed 3-26-23. -Levothyroxine (hypothyroidism) 137 mg 1 by</p>	V 118		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL018-102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2023
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NAME OF PROVIDER OR SUPPLIER PINNACLE THERAPEUTIC SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 2329 SPRINGS ROAD, NORTH EAST HICKORY, NC 28601
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V 118	<p>Continued From page 70</p> <p>mouth daily in the morning dispensed 3-22-23. -Hydroxyzine Hydrochloride (HCL) (anxiety and allergies) 25 mg 1 by mouth twice daily as needed for anxiety dispensed 4-3-23. -Fanapt (psychosis) 2 mg 1 by mouth twice daily with breakfast and dinner dispensed 3-30-23. -Metformin HCL (diabetes and polycystic ovarian syndrome (PCOS)) 500 mg 1 by mouth daily with meals dispensed 3-26-23. -Metoprolol Succinate Extended Release (ER) (mood) 25 mg 2 by mouth daily dispensed 4-3-23.</p> <p>Review on 4-12-23 of Client #1's MARs for February 2023 through April 2023 revealed: -No evidence of MARs for any medications on the dates of 2-24-23 through 4-6-23. -No evidence of MARs for any medications on the dates of 4-7-23 through 4-12-23 with the exception of metoprolol succinate. -MAR dated 4-7-23 through 4-12-23 had no time of medication administration for Metoprolol Succinate on 4-7-23.</p> <p>Review on 4-12-23 of Client #2's record revealed: -Age: 16 years old. -Date of Admission: 2-21-23. -Diagnoses: Per local hospital discharge summary dated 2-21-23 Bipolar Disorder, Rare Mixed with Psychotic Effects; PTSD; Rule Out (R/O) ADHD; Oppositional Defiant Disorder (ODD); Cluster B Personality Traits. -Physician's order dated 2-21-23, 3-8-23, and 4-7-23 for Lithium (mood disorders) 300 mg 1 by mouth twice daily.</p> <p>Observation on 4-12-23 at 12:10 pm of Client #2's medications revealed: -Lithium 300 mg 1 by mouth twice daily dispensed on 4-7-23.</p>	V 118		

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V 118	<p>Continued From page 71</p> <p>Review on 4-12-23 of Client #2's MARs for February 2023 through April 2023 revealed:</p> <ul style="list-style-type: none"> -On 3-30-23 lithium was documented as given at 9am and 9pm on two separate MARs; -On 3-31-23 lithium was documented as given at 9am and 9 pm on one MAR and at 8am on another MAR. -On 4-1-23 lithium was documented as given at 9am and 8:30 pm on one MAR. -On 4-1-23 lithium was documented as given at 9:48 am and 8:30 pm on another MAR. -There were no staff signatures for the dates of 4-8-23 at 8pm; 4-9-23 at 8am; 4-9-23 at 8pm and 4-10-23 at 8am. -Unable to determine the number of times lithium was administered on 3-30-23, 3-31-23 and 4-1-23. -Unable to determine if lithium was administered on 4-8-23, 4-9-23 and 4-10-23. <p>Review on 4-12-23 of Client #3's record revealed:</p> <ul style="list-style-type: none"> -Age: 12 years old. -Date of Admission: 3-1-23. -Diagnoses: <ul style="list-style-type: none"> -Per local hospital document dated 2-15-23 Disruptive Mood Dysregulation Disorder. -Per application dated 3-1-23 ODD, Moderate; ADHD; PTSD. -No evidence of physician's orders for any medications. <p>Observation on 4-12-23 at 10:43 am of Client #3's medications revealed:</p> <ul style="list-style-type: none"> -Clonidine HCL ER (high blood pressure and mood disorders) 0.2 mg 1 by mouth twice daily dispensed 3-9-23. -Oxcarbazepine (seizures and mood disorders) 600 mg 1 by mouth twice daily dispensed 11-28-22. -Quetiapine Fumarate (mood disorders) 200 mg 1 	V 118		

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V 118	<p>Continued From page 72</p> <p>by mouth twice daily dispensed 4-5-23. -Jornay PM (nightly) 100 mg (ADHD) 1 by mouth at bedtime dispensed 4-11-23. -Sertraline HCL (mood disorders) 100 mg 1 by mouth every night at bedtime dispensed 4-5-23.</p> <p>Review on 4-12-23 of Client #3's MARs for March 2023 through April 2023 revealed: -No evidence of MARs for clonidine from 3-1-23 through 3-9-23, or from 3-23-23 through 4-3-23. -The time of medication administration was left blank for clonidine on 3-17-23 and 4-5-23. -There were no staff signatures for the am or pm doses of clonidine on 4-5-23. -FS #12 was the only staff signature indicating administration for the am and pm doses of clonidine on 3-4-23, 3-7-23, and 3-13-23. -FS #12 and FS #13 were the only signatures indicating administration of clonidine on 3-9-23. -On 4-11-23 documentation that Quetiapine Fumarate was given twice at 8am and given again at 8 pm for a total of 3 doses instead of 2. -No MARs for Quetiapine Fumarate from 3-1-23 through 4-10-23. -The time of medication administration was left blank for oxcarbazepine on 3-13-23, 3-17-23 and 4-5-23. -FS #12 was the only staff signature indicating administration of oxcarbazepine dated 3-3-23, 3-4-23, 3-7-23 and 3-13-23. -No evidence of MARs for Jornay from 3-1-23 through 3-11-23, or from 3-28-23 through 4-9-23. -No record that Jornay was administered on 3-13-23. -No evidence of MARs for sertraline.</p> <p>Review on 4-12-23 of Client #4's record revealed: -Age: 15 years old. -Date of Admission: 2-23-23. -Diagnoses: Not identified in the record.</p>	V 118		

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V 118	<p>Continued From page 73</p> <p>-No evidence of physician's orders for any medications.</p> <p>Observation on 4-12-23 at 12:25 pm of Client #4's medications revealed:</p> <p>-Vyvanse (ADHD, seizures and mood disorders) 50 mg 1 by mouth daily for 21 days dispensed 3-26-23.</p> <p>-Metformin HCL ER (diabetes and PCOS) 750 mg 1 by mouth twice daily for 21 days dispensed 3-26-23.</p> <p>-Sulfamethoxazole/trimethoprim Double Strength (DS) (infections) 800/160 mg 1 by mouth twice daily for 10 days dispensed 3-28-23.</p> <p>-Risperidone (mood disorders) 2 mg take 1 by mouth twice daily dispensed 3-16-23.</p> <p>-Divalproex Sodium Delayed Release (DR) (seizures and mood disorders) 250 mg 3 by mouth twice daily dispensed 3-13-23.</p> <p>-Mupirocin (infections) 2% ointment apply to affected area three times daily for 10 days dispensed 3-28-23.</p> <p>-Nystatin Topical (fungal infections) 100,000 units per gram (gm) apply to affected area twice daily dispensed 3-13-23.</p> <p>-Cetirizine HCL (allergies) 10 mg 1 by mouth daily as needed (PRN) for allergy symptoms for 30 days dispensed 3-26-23.</p> <p>-Desmopressin Acetate (diabetes and frequent urination) 0.2 mg 2 by mouth at bedtime for 21 days dispensed 3-26-23.</p> <p>-Topiramate (seizures and migraines) 50 mg 1 by mouth at bedtime for 21 days dispensed 3-26-23.</p> <p>Review on 4-12-23 of Client #4's MARs for February 2023 through April 2023 revealed:</p> <p>-No evidence of MARs for Vyvanse, Metformin, sulfamethoxazole/trimethoprim, or risperidone until 4-10-23.</p> <p>-No evidence of MARs for divalproex sodium,</p>	V 118		

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V 118	<p>Continued From page 74</p> <p>mupirocin, nystatin, cetirizine, desmopressin acetate, or topiramate from 2-23-23 to 4-12-23.</p> <p>Review on 4-19-23 of Client #5's record revealed: -Age: 16 years old. -Date of Admission: 4-10-23. -Diagnoses: Conduct Disorder. -No evidence of physician's orders for fluticasone spray, or for cortisone cream. -No evidence of physician's order for Prozac from 4-10-23 through 4-11-23. -An order for Prozac 40 mg by mouth daily dated 4-12-23 and faxed from a local pediatric office to the facility on 4-12-23 at 12:33 pm.</p> <p>Observation on 4-13-23 at 10:43 am of Client #5's Medications revealed: -Fluticasone Propionate (allergies) 50 mcg 1 spray in each nostril daily dispensed on 3-29-23. -Fluoxetine (mood disorders) 40 mg 1 by mouth daily in the morning dispensed on 3-27-23.</p> <p>Review on 4-13-23 of Client #5's MARs for April 2023 revealed: -No documentation that medications had been administered.</p> <p>Review on 4-12-23 of FC #7's record revealed: -Age: 15 years old. -Date of Admission: 2-19-23. -Date of Discharge: Not identified in the record. -Diagnoses: Per application dated 2-19-23 ADHD; PTSD. -Physician's orders dated 2-21-23 for the following: - Clonidine HCL ER (high blood pressure and mood disorders) 0.1mg 1-2 (no route) at bedtime PRN sleep. - Clonidine HCL (high blood pressure and mood disorders) 0.2 mg 1 by mouth nightly PRN</p>	V 118		

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V 118	<p>Continued From page 75</p> <p>(no reason indicated).</p> <ul style="list-style-type: none"> - Fluticasone Propionate (allergies) 50 mcg 1-2 sprays into both nostrils daily. -Adderall XR (Extended Release) (ADHD) 20 mg 1 by mouth in the morning on school days. -Fluoxetine HCL (mood disorders) 20 mg 1 by mouth daily. -No evidence of physician's orders for ondansetron (nausea), Prevident/sodium fluoride (sensitive teeth), or methylprednisolone (allergies and inflammation). <p>Review on 4-12-23 of FC #7's MARs for February 2023 through April 2023 revealed:</p> <ul style="list-style-type: none"> -MAR dated 3-25-23 through 3-31-23 for Methylprednisolone 4mg 6 tablets on day 1 as directed on package and decrease by 1 tablet each day for a total of 6 days was documented as refused by client for all dates. -MAR dated for 3-23-23 through 3-27-23 for ondansetron orally disintegrating tablet (ODT) 4mg 1 by mouth every 8 hours PRN. There was no indication of the reason to administer the ondansetron. Documentation indicated that the medication was offered approximately every 12 to 24 hours, instead of every 8 hours. -MARs dated 2-26-23 through 4-12-23 for Prevident/sodium fluoride 5000 parts per million (PPM) use as directed once daily had no administration times documented for 2-27-23 through 3-9-23, 3-13-23 through 3-14-23, 3-16-23 through 3-17-23, and 3-25-23 and there were no staff signatures for 2-28-23 through 3-9-23, 3-11-23, 3-16-23, and 3-19-23. -No evidence of MARs for clonidine HCL 0.2 mg from 2-21-23 through 3-6-23. -Clonidine HCL 0.2 mg was documented as scheduled instead of PRN on the MARs dated 3-22-23 through 4-12-23. -FS #12 was the only staff signature indicating 	V 118		

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V 118	<p>Continued From page 76</p> <p>administration of clonidine on 3-7-23. -FS #13 was the only staff signature indicating administration of clonidine on 3-9-23. -Clonidine HCL 0.2 mg was offered in the morning instead of at night on 3-9-23. Documented as a refusal. -Clonidine HCL 0.1 mg was documented as scheduled instead of PRN on the MARs dated 2-21-23 through 4-11-23. -Clonidine HCL 0.1 mg was administered twice on 2-22-23. -FS #12 was the only staff signature indicating administration of clonidine HCL 0.1 mg on 2-23-23 through 2-25-23, 3-5-23, and 3-7-23. -Both FS #12 and FS #13 were the signatures indicating administration of clonidine HCL 0.1 mg on 2-22-23, 2-28-23 and 3-1-23. -There were no staff signatures for clonidine HCL 0.1 mg on 3-6-23 and 3-30-23. -There were no administration times documented for fluticasone propionate on 2-21-23, 2-24-23, 3-4-23, 3-9-23, 3-11-23, and 3-13-23 through 3-21-23. -FS #12 was the only staff signature indicating administration of fluticasone propionate on 3-13-23. -Both FS #12 and FS #13 were the signatures indicating administration of fluticasone propionate on 2-22-23, 2-23-23 and 3-7-23. -There were no staff signatures for fluticasone propionate on 2-21-23 and 2-25-23. -Adderall XR was documented to be administered "every day ..." instead of just on school days on 2-21-23 through 3-23-23. -Adderall XR was offered in the evening instead of in the morning on 2-23-23 and 4-4-23. -There were no administration times documented for Adderall XR on 2-21-23 or 2-24-23. -FS #12 was the only staff signature indicating administration of Adderall XR on 2-23-23.</p>	V 118		

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V 118	<p>Continued From page 77</p> <p>-FS #13 was the only staff signature indicating administration of Adderall XR on 2-21-23.</p> <p>-FS #12 and FS #13 were the signatures indicating administration of Adderall XR on 2-22-23 and 3-7-23.</p> <p>-There were no administration times documented for fluoxetine HCL on 2-21-23, 2-24-23 through 2-26-23, 3-3-23 through 3-4-23, 3-7-23, 3-11-23, and 3-15-23 through 3-18-23.</p> <p>-FS #12 was the only staff signature indicating administration of fluoxetine HCL on 3-7-23.</p> <p>-FS #13 was the only staff signature indicating administration of fluoxetine HCL on 2-21-23 and 3-9-23.</p> <p>-FS #12 and FS #13 were the signatures indicating administration of fluoxetine HCL on 2-22-23 and 2-23-23.</p> <p>Interview on 4-11-23 with Client #1 revealed: -She refused to take any of her medications and stated, "I've been refusing all of them for a good 3 weeks, but I'm back taking them now."</p> <p>Interview on 4-11-23 with Client #3 revealed: - "...Staff sometimes give it (medication) to us wrong and give us the wrong meds (medication) and we tell them that, but I know what meds I take, and I take them all the time ...so I just take them even though they are wrong ..."</p> <p>Interview on 4-11-23 with Client #5 revealed: -She did not take any prescription medications.</p> <p>Interview on 4-13-23 with Staff #1 revealed: -"All the clients know their medicine, we identify (medications) by the prescription off the MAR sheet."</p> <p>Interview on 4-19-23 with Staff #2 revealed: -Client #5 refused to take medications.</p>	V 118		

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V 118	<p>Continued From page 78</p> <p>Interview on 4-13-23 with Staff #5 revealed: -To confirm medication administration accuracy, she would "look at the date and the person (client) I am giving it to."</p> <p>Interview on 4-17-23 with FS #12 revealed: -When the facility first opened, "me and [QP/PD] were the only two people certified in med (medication) pass ..."</p> <p>Interview on 4-17-23 with the QP/PD revealed: -MAR oversight "comes from the Program Manager (QP/PD), we have a Program Assistant (Staff #1) that looks at it (MARs) first ..." -" ... all staff need to know how to type the MAR, so we (facility staff) have a blank docket MAR, and then [Staff #1], or myself will enter the medications as they come in ... If meds (medications) come in (during) the weekend, staff need to be able to document. Monday-Friday would be me, or [Staff #1] would do that ..." -There was no system in place to ensure that staff documented medications accurately on the MARs. -"We will get something in place with that and I will do a weekly review, even though [Staff #1] is looking at them on a daily and that will be part of my correction and I will make a spreadsheet to ensure that these (medications) are given accurately ..." -Upon a client's admission to the facility "We look for the doctor order, the medication leaflet and information. If they (clients) come without a doctor order, we do not administer the medication, and I request staff have the guardian to take the medication back, or we attempt to send the meds (medications) back. Even if it's on the bottle, we must have a doctor order to give meds here ..." -"We had original doctors' orders but we took</p>	V 118		

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V 118	<p>Continued From page 79</p> <p>them out and added the list of what was documented in the hospital."</p> <p>Interview on 4-19-23 with the Licensee revealed: -"When I ask (staff) how is medication going? I hear it is no problem ..." -Did not think there were "egregious errors" with medications.</p> <p>Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician.</p> <p>This deficiency is cross referenced into 10A NCAC 27E .0101 Least Restrictive Alternative (V513) for a Type A1 rule violation and must be corrected within 23 days.</p>	V 118		
V 123	<p>27G .0209 (H) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted.</p> <p>.</p> <p>This Rule is not met as evidenced by: Based on record reviews, observation and</p>	V 123		

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V 123	<p>Continued From page 80</p> <p>interviews, the facility failed to ensure medication errors were reported immediately to a physician or pharmacist affecting 2 of 5 current clients (Client #2 and #3) and 1 of 4 Former Clients (FC #7). The findings are:</p> <p>Review on 4-12-23 of Client #2's record revealed: -Age: 16 years old. -Date of Admission: 2-21-23. -Diagnoses: Per local hospital discharge summary dated 2-21-23 Bipolar Disorder, Rare Mixed with Psychotic Effects; PTSD; Rule Out (R/O) ADHD; Oppositional Defiant Disorder (ODD); Cluster B Personality Traits. -Physician's order dated 2-21-23, 3-8-23, and 4-7-23 for Lithium (mood disorders) 300 milligram (mg) 1 by mouth twice daily. -No evidence of consultation with a pharmacist, or physician for medication errors.</p> <p>Review on 4-12-23 of Client #2's MARs for February 2023 through April 2023 revealed: -On 3-30-23 Lithium was documented as given at 9am and 9pm on two separate MARs; -On 3-31-23 Lithium was documented as given at 9am and 9 pm on one MAR and at 8am on another MAR. -On 4-1-23 Lithium was documented as given at 9am and 8:30 pm on one MAR. -On 4-1-23 Lithium was documented as given at 9:48 am and 8:30 pm on another MAR. -Unable to determine the number of times Lithium was administered on 3-30-23, 3-31-23 and 4-1-23. -Unable to determine if Lithium was administered on 4-8-23, 4-9-23 and 4-10-23.</p> <p>Review on 4-12-23 of Client #3's record revealed: -Age: 12 years old. -Date of Admission: 3-1-23.</p>	V 123		

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V 123	<p>Continued From page 81</p> <p>-Diagnoses: -Per local hospital document dated 2-15-23 Disruptive Mood Dysregulation Disorder. -Per application dated 3-1-23 ODD, Moderate; ADHD; PTSD.</p> <p>-No evidence of consultation with a pharmacist, or physician for medication errors.</p> <p>Observation on 4-12-23 at 10:43 am of Client #3's medications included: -Quetiapine Fumarate (mood disorders) 200 mg 1 by mouth twice daily dispensed 4-5-23.</p> <p>Review on 4-12-23 of Client #3's MARs for March 2023 through April 2023 revealed: -On 4-11-23 documentation that Quetiapine Fumarate was given twice at 8am and given again at 8 pm for a total of 3 doses instead of 2.</p> <p>Review on 4-12-23 of FC #7's record revealed: -Age: 15 years old. -Date of Admission: 2-19-23. -Date of Discharge: Not identified in the record. -Diagnoses: Per application dated 2-19-23 ADHD; PTSD. -Physician's orders dated 2-21-23 for the following: - Clonidine HCL ER (high blood pressure and mood disorders) 0.1mg 1-2 (no route) at bedtime PRN sleep. - Clonidine HCL (high blood pressure and mood disorders) 0.2 mg 1 by mouth nightly PRN (no reason indicated). - Fluticasone Propionate (allergies) 50 mcg 1-2 sprays into both nostrils daily. -Adderall XR (Extended Release) (ADHD) 20 mg 1 by mouth in the morning on school days. -Fluoxetine HCL (mood disorders) 20 mg 1 by mouth daily. -No evidence of physician's orders for</p>	V 123		

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V 123	<p>Continued From page 82</p> <p>Prevident/sodium fluoride (sensitive teeth), or methylprednisolone (allergies and inflammation).</p> <p>Review on 4-12-23 of FC #7's MARs for February 2023 through April 2023 revealed:</p> <ul style="list-style-type: none"> -MAR dated 3-25-23 through 3-31-23 for Methylprednisolone 4mg 6 tablets on day 1 as directed on package and decrease by 1 tablet each day for a total of 6 days was documented as refused by client for all dates. -Clonidine HCL 0.2 mg was offered in the morning instead of at night on 3-9-23. Documented as a refusal. -Clonidine HCL 0.1 mg was administered twice on 2-22-23. -Adderall XR was documented to be administered "every day ..." instead of just on school days on 2-21-23 through 3-23-23. -Adderall XR was offered in the evening instead of in the morning on 2-23-23 and 4-4-23. -Adderall XR was not documented as having been administered on 2-21-23, and 2-24-23 through 2-26-23 -FC #7 refused Adderall XR on 2-28-23, 3-1-23, 3-4-23 through 3-6-23, 3-8-23, 3-10-23 through 3-13-23, and 3-15-23 through 4-7-23. -Fluoxetine HCL was not documented as having been administered on 2-21-23. -FC #7 refused fluoxetine HCL on 2-24-23 through 3-13-23, and 3-15-23 through 4-7-23. -Fluticasone propionate was not documented as having been administered on 2-21-23, 2-25-23, and 3-9-23. -FC #7 refused fluticasone propionate on 2-26-23 through 3-8-23 and 3-10-23 through 4-7-23. -Prevident/sodium fluoride was not documented as having been administered on 3-16-23. -FC #7 refused Prevident/sodium fluoride on 2-26-23 through 3-21-23, 3-23-23 through 3-26-23, and 3-28-23 through 4-6-23. 	V 123		

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V 123	<p>Continued From page 83</p> <p>-FC #7 was documented as being "AWOL" (absent without leave) from the evening of 4-7-23 through 4-12-23 on all MARs.</p> <p>Review on 4-13-23 of the facility's internal incident reports revealed: -There were no incident reports for client refusals of medications, or medication administration errors</p> <p>Interview on 4-13-23 with Staff #1 revealed: -When clients refused medications, she would "Ask them again to see if they changed their mind and if they don't, I record it and sometimes they will act up and you can tell they haven't been on their meds at all. We had one like that and she got admitted. [FC #7] never took her meds at all ..."</p> <p>-Medication errors were reported to " ...their social worker (Department of Social Services) usually knows. When they (social workers) check up on them (clients), we tell them that they aren't taking their meds (medications), and then they go to the hospital when they are having a behavior problem."</p> <p>Interview on 4-13-23 with Staff #5 revealed: -If there was a medication error "I notify the next shift and log a refusal and sign the book."</p> <p>Interview on 4-17-23 with the Qualified Professional/Program Director (QP/PD) revealed: -"We (staff) document a refusal (of medications) and we put it in a note and after 3 doses of refusal, we speak with the legal guardian to speak with the doctor in order to see if there is anything different we are supposed to be doing and what the doctor recommends like continue the meds, or discontinue the meds and staff fill out an incident report ... I am ultimately</p>	V 123		

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V 123	Continued From page 84 responsible for incident reports ..." Interview on 4-19-23 with the Licensee revealed: -Did not think there were "egregious errors". This deficiency is cross referenced into 10A NCAC 27E .0101 Least Restrictive Alternative (V513) for a Type A1 rule violation and must be corrected within 23 days.	V 123		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by: Based on record reviews, observation and interviews, the facility failed to access the Health Care Personnel Registry (HCPR) prior to hiring health care personnel affecting 11 of 11 current staff (Staff #1-11) and 2 of 2 Former Staff (FS #12 and #13). The findings are: Review on 4-13-23 of Staff #1-#3, #5, #9 and FS #13's personnel record revealed: -No evidence of date of hire. -HCPR check completed on 4-12-23.	V 131		

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V 131	<p>Continued From page 85</p> <p>Review on 4-13-23 of Staff #4, #11 and FS #12's personnel record revealed: -No evidence of date of hire. -No evidence of HCPR check.</p> <p>Review on 4-13-23 of Staff #6-#8, and #10's personnel record revealed: -No evidence of date of hire. -HCPR check completed on 3-13-23.</p> <p>Record review and interviews with staff during the survey regarding requests for personnel records revealed: -Personnel records were not received from Staff #1 as requested on 4-12-23. -A second request made to Staff #1 on 4-13-23 at 8:55 am. -A request to Staff #5 on 4-13-23 for the personnel record of the Licensee. -Records for Staff #'s 1-10 and FS #13 were provided by Staff #1 on 4-13-23 at 9:10 am. -On 4-13-23 at 11:18 am, the Licensee provided the personnel record for Qualified Professional (QP)/Program Director (PD) and stated that he would have to go to his office for the FS #12's personnel record. -On 4-13-23 at 2:52 pm, another request was made to the Licensee for the personnel record of FS #12 and a first request was made for the personnel record of Staff #11 (who was observed working on 4-11-23). The Licensee stated "He (Staff #11) just started here. He has only worked for a week, so I don't have much of a file on him. I can get what I have available, like his application." (which was never provided during the survey). -On 4-13-23 at 3:00 pm the Licensee provided the personnel record for FS #12. -On 4-17-23 an additional request was made for</p>	V 131		

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V 131	<p>Continued From page 86</p> <p>the personnel record of Staff #11 that was never received.</p> <p>Review on 4-12-23 of "Pinnacle Therapeutic Services Daily Progress Notes" for Former Client (FC) #8 dated 3-3-23 revealed: -Staff #6 signed the progress note for 3-3-23.</p> <p>Review on 4-12-23 of Client #3's Medication Administration Records (MARs) revealed: -Staff #7 signed the MAR on 3-12-23.</p> <p>Review on 4-12-23 of FC #7's MARs revealed: -Staff #1 signed the MAR on 3-28-23. -Staff #3 signed the MAR on 4-2-23. -Staff #8 signed the MAR on 3-11-23. -Staff #9 signed the MAR on 3-22-23. -Staff #10 signed the MAR on 3-16-23. -FS#12 and #13 signed the MAR on 2-22-23.</p> <p>Observation of the facility on 4-11-23 at 2:15 pm revealed: -Staff #11 was present in the facility with clients.</p> <p>Interview on 4-18-23 with Staff #2 revealed: -She started working at the facility on 3-23-23.</p> <p>Interview on 4-18-23 with Staff #4 revealed: -"Last week was my first week..."</p> <p>Interview on 4-13-23 with Staff #5 revealed: -Began working at the facility in February 2023. -"[Licensee] is the owner so I don't think he has a file." She would call the Licensee and ask him.</p> <p>Interview on 4-17-23 with FS #12 revealed: -She worked at the facility from 2-2-23 through 3-21-23.</p> <p>Interviews on 4-17-23 and 4-19-23 with the</p>	V 131		

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V 131	<p>Continued From page 87</p> <p>Qualified Professional/Program Director (QP/PD) revealed: -"I'm looking for [Staff #11]'s chart." -For HCPR checks, "...We have an individual at the office who does it but I am supposed to follow up that it's done as I am the supervisor ... I don't know her name, she is at the main office so I don't want to lie about names." -In regard to the items not being in the file, "I am in the loop and have been told ..."</p> <p>Interview on 4-19-23 with the Licensee revealed: -"I've been keeping up personnel records currently but we are bringing in a person to do it on a daily basis." -In the meantime, "I will be responsible." -"That would be the person I bring on board. I have been doing it." (person responsible for completing HCPR and background checks)</p> <p>This deficiency is cross referenced into 10A NCAC 27E .0101 Least Restrictive Alternative (V513) for a Type A1 rule violation and must be corrected within 23 days.</p>	V 131		
V 132	<p>G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection</p> <p>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</p>	V 132		

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V 132	<p>Continued From page 88</p> <p>as defined by G.S. 131E-201 are being provided.</p> <p>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.</p> <p>c. Misappropriation of the property of a healthcare facility.</p> <p>d. Diversion of drugs belonging to a health care facility or to a patient or client.</p> <p>e. Fraud against a health care facility or against a patient or client for whom the employee is providing services).</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report and investigate all allegations of abuse against health care personnel and failed to protect clients from harm</p>	V 132		

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V 132	<p>Continued From page 89</p> <p>during the investigation process. The findings are:</p> <p>Finding #1: Review on 4-12-23 of Client #4's record revealed: -Age: 15 years old. -Date of Admission: 2-23-23. -Diagnoses: Not identified in the record.</p> <p>Review on 4-11-23 and 4-19-23 of the facility records revealed: -No documentation of a report of allegations to the Health Care Personnel Registry (HCPR).</p> <p>Review on 4-13-23 of the facility internal incident reports for February 2023 through April 2023 revealed: -No incident report for the allegations made against Staff #1 by Client #4 on 4-11-23.</p> <p>Review on 4-19-23 of the Local Police Department Incident/Investigation Report dated 4-11-23 revealed: -4-11-23 at 1:03 pm law enforcement responded "in reference to a juvenile (Client #4) acting disorderly. Upon my (Law Enforcement Officer (LEO)) arrival ... [Client #4] at the time was attempting to use a screw driver to disable a door lock to the office. I (LEO) took the screw driver from [Client #4] for safety reasons ...[Client #4] advised that she was upset because [Staff #1] had made her cry earlier ...that [Staff #1] yelled at her ...then shoved her ...[Client #4] additionally advised that she no longer wished to remain at the facility ...[Staff #1] advised that [Client #4] was inside of her (Staff #1's) office even though no juveniles are permitted to be inside of the office without an adult present ...[Staff #1] advised that [Client #4] would not move so that she (Staff #1) could walk to her desk. [Staff #1] advised that she squeezed past [Client #4] and [Client #4]</p>	V 132		

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V 132	<p>Continued From page 90</p> <p>stated for [Staff #1] not to put her hands on her ...a short time later [Client #4] poured water all over [Staff #1's] desk to include her (Staff #1's) office computer ..."</p> <p>Interview on 4-12-23 with Client #4 revealed: -"I got pushed by [Staff #1] yesterday in the office..."</p> <p>Interview on 4-13-23 with Staff #1 revealed: -"She (Client #4) said I touched her and that I hit her, but all I did was walk past her. She'll be grabbing scissors and stuff like that, so I just move myself out of the area to a safe place and then I let the police handle it because I am not going to be hurt. We (staff) can't touch them (clients), and they know that. She went and called the police first and then went to the office to stand in front of me and I squeezed by her to get out of harms way and she tried to body block me and she got really upset ..."</p> <p>Interview on 4-17-23 with Qualified Professional/Program Director (QP/PD) revealed: -On 4-11-23 "She (Client #4) called police on [Staff #1] saying she assaulted her. She (Client #4) wanted us to call the social worker (SW) which we did and she didn't like the information which was provided by the SW's. [Staff #1] tried to have [Client #4] step aside in the office so she (Staff #1) could get passed her (Client #4) and [Client #4] called the police and said she (Staff #1) pushed her ..." -The facility " ...informed the social worker and her (Client #4) report to the officer made him feel he didn't need to move any further with it and there were 2 staff present when she (Client #4) made the allegation and they both informed us that [Staff #1] actions was just passing by her and we documented it on an incident report and that</p>	V 132		

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V 132	<p>Continued From page 91</p> <p>was it." -Acknowledged that an investigation was not completed. " ...I need to do a better job with the investigation and documentation piece."</p> <p>Interview on 4-19-23 with the Licensee revealed: -Process for allegations of abuse/neglect against a staff member " ...document, create an incident report, report to police, report to IRIS. I don't think it was reported to IRIS."</p> <p>Finding #2:</p> <p>Review on 4-12-23 of FC #6's record revealed: -Age: 15 years old. -Date of Admission: 2-15-23. -Date of Discharge: Not identified in the record.</p> <p>Review on 4-11-23 and 4-19-23 of the facility records revealed: -No documentation of a report of allegations to the Health Care Personnel Registry (HCPR).</p> <p>Review on 4-13-23 of a facility internal incident report dated 3-30-23 revealed: -"...As staff (Qualified Professional/Program Director (QP/PD)) stood at the top of the stairs [FC #6] came out of his bedroom cussing and threaten to kick staff a*s if I (QP/PD) did not go back downstairs. [FC #6] approached and pushed staff (QP/PD) then started pointing his finger in staff 's (QP/PD's) face making contact, while making statements that he (FC #6) was going to kick staff's (QP/PD's) a*s because staff (QP/PD) feared him. Staff (QP/PD) requested [FC #6] to stop and return to his bedroom ... [FC #6] continues to demonstrate aggressive behavior by pushing staff (QP/PD) for the second time, but with more aggression. Staff (QP/PD) started falling down the stairs after the second</p>	V 132		

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V 132	<p>Continued From page 92</p> <p>push from [FC #6]. The staff's (QP/PD's) natural reaction was to grab something to prevent me (QP/PD) from falling from the top of the stairs to the bottom. Staff (QP/PD) grabbed [FC #6] and both of us went falling down the stairs. Once we reached the bottom of the stairs [FC #6] continued to assault staff (QP/PD). Staff (QP/PD) extended his right arm and placed it on [FC #6] chest/neck area to prevent him from grabbing me (QP/PD). Another youth (Client #2) intervened by grabbing [FC #6] to help de-escalate the situation ..."</p> <p>-No evidence of an internal investigation, or documentation that HCPR was notified.</p> <p>Interview on 4-11-23 with Client #1 revealed: -" ...[QP/PD] somewhat put hands on, it was like you know, I'm gonna say this, I'm not gonna snitch, it was seeing anger because I know what it feels like to get beat on, but the boy (FC #6) that was here before had anger problems and all I heard was they (QP/PD and FC #6) were both in each other's face and then I heard duke, duke, duke and then the boy (FC #6) was down on his face and up against the wall and all like that ..."</p> <p>Interview on 4-11-23 with Client #2 revealed: -He observed FC #6 try to push the QP/PD down the stairs and the QP/PD had to defend himself.</p> <p>Interview on 4-11-23 with Client #3 revealed: - " ...well, there was this kid named [FC #6] and [QP/PD] choked him and pushed him against the wall and yesterday, [QP/PD] choked me. I think he (QP/PD) is unfit, and they (staff) don't have any experience and they (Licensee) hire new people all the time and they are very new ..."</p> <p>Interviews on 4-11-23 and 4-12-23 with Client #4 revealed:</p>	V 132		

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V 132	<p>Continued From page 93</p> <p>- "...[QP/PD] had one of the boys (FC #6) that is no longer here by his neck on the wall and on the ground by the stairwell by his neck. This was like 2-3 weeks ago ...I saw the [QP/PD] choke [FC #6] ..."</p> <p>Attempts were made on 4-14-23 and 4-17-23 to interview FC #6's guardian but were unsuccessful.</p> <p>Attempts were made on 4-17-23 to interview FC #6 but were unsuccessful.</p> <p>Interview on 4-17-23 with QP/PD revealed: -"[Client #3] and [Client #1] were upstairs arguing and I went up the stairs and got to the top of the stairs and started redirecting them and as I'm encouraging them to stop, [FC #6] came out of his bedroom and started yelling and pushed me and he pushed me down one step. I asked him to please stop touching me. All the kids came out of their rooms and gathered to see what was going on. I kept telling [FC #6] that this had nothing to do with him. He popped me in the head and pushed me and I felt like I was falling down the steps and my first reaction was to grab the first thing which was him and we both fell down the steps. We got up and I put my hands up to tell him to go the other way and he pushed me, and the kids were yelling for [FC #6] to stop. [Client #2] got [FC#6], and I got the social workers, and did my incident report and he (FC #6) was discharged. The same individuals that told me how professional I was in handling this is the same individual that got y'all out here. People were thinking I choked him. He was the aggressor. If I wasn't on the steps, I could have moved back. I had my arm extended and he was trying to grab me, and we are no hands on and he was trying to grab me and I was repeating please</p>	V 132		

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V 132	<p>Continued From page 94</p> <p>go the other way, please go the other way. I never had my arms around him as if I was choking him. [Client #1] said, '[QP/PD] you're choking him.' I wasn't choking him. That's when [Client #2] said come on [FC #6] you need to stop what you're doing."</p> <p>Interview on 4-19-23 with the Licensee revealed: -" ...It was for an incident between [QP/PD] and a discharged client (FC #6) from my understanding. I will say that you guys have looked at the discharged clients history and his stay while he was here and I think we did a decent job of documenting the physical of what he did while he was here like wanting to break windows and wanting to do bodily harm so when that happened I did ask what transpired and even the kids (clients) were saying he (QP/PD) was protecting himself from physical harm ..." -Process for allegations of abuse/neglect against a staff member " ...document, create an incident report, report to police, report to IRIS. I don't think it was reported to IRIS."</p> <p>This deficiency is cross referenced into 10A NCAC 27E .0101 Least Restrictive Alternative (V513) for a Type A1 rule violation and must be corrected within 23 days.</p>	V 132		
V 133	<p>G.S. 122C-80 Criminal History Record Check</p> <p>G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT. (a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse</p>	V 133		

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V 133	Continued From page 95 services that is licensable under Article 2 of this Chapter. (b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the	V 133		

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V 133	<p>Continued From page 96</p> <p>information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency.</p> <p>(c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant:</p> <ol style="list-style-type: none"> (1) The level and seriousness of the crime. (2) The date of the crime. (3) The age of the person at the time of the conviction. (4) The circumstances surrounding the commission of the crime, if known. (5) The nexus between the criminal conduct of the person and the job duties of the position to be filled. 	V 133		

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V 133	<p>Continued From page 97</p> <p>(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.</p> <p>(7) The subsequent commission by the person of a relevant offense.</p> <p>The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.</p> <p>(d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for:</p> <p>(1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual.</p> <p>(2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section.</p> <p>(e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers;</p>	V 133		

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V 133	<p>Continued From page 98</p> <p>Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.</p> <p>(f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor.</p> <p>(g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record</p>	V 133		

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V 133	<p>Continued From page 99</p> <p>check regarding the applicant if both of the following requirements are met:</p> <p>(1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10.</p> <p>(2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.)</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to request a criminal history record check within 5 days of an offer of employment affecting the Licensee, 11 of 11 current staff (Staff #'s1-11) and 2 of 2 Former Staff (FS #12 and #13). The findings are:</p> <p>Review on 4-13-23 of Staff #1-#11, FS #12-#13 and the Licensee's personnel record revealed: -No evidence of date of hire. -No evidence of a criminal history record check.</p> <p>Record review and interviews with staff during the survey regarding requests for personnel records revealed: -Personnel records were not received from Staff #1 as requested on 4-12-23. -A second request made to Staff #1 on 4-13-23 at 8:55 am. -A request to Staff #5 on 4-13-23 for the</p>	V 133		

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V 133	<p>Continued From page 100</p> <p>personnel record of the Licensee.</p> <p>-Records for Staff #'s 1-10 and FS #13 were provided by Staff #1 on 4-13-23 at 9:10 am.</p> <p>-On 4-13-23 at 11:18 am, the Licensee provided the personnel record for Qualified Professional/Program Director (QP/PD) and stated that he would have to go to his office for the FS #12's personnel record.</p> <p>-On 4-13-23 at 2:52 pm, another request was made to the Licensee for the personnel record of FS #12 and a first request was made for the personnel record of Staff #11 (who was observed working on 4-11-23). The Licensee stated "He (Staff #11) just started here. He has only worked for a week, so I don't have much of a file on him. I can get what I have available, like his application." (which was never provided during the survey).</p> <p>-On 4-13-23 at 3:00 pm the Licensee provided the personnel record for FS #12.</p> <p>-On 4-17-23 an additional request was made for the personnel record of Staff #11 that was never received.</p> <p>Interview on 4-13-23 with Staff #5 revealed: -"[Licensee] is the owner so I don't think he has a file." She would call the Licensee and ask him.</p> <p>Interviews on 4-13-23 with the Licensee revealed: " ...but I am not an employee, I just handle the business, you may have seen me talking to her (Client #4) yesterday; I don't do care."</p> <p>Interview on 4-17-23 and 4-19-23 with the QP/PD revealed: -"I'm looking for [Staff #11]'s chart." -For personnel records "My role is supposed to be to sit in with hiring, do the reference checks, ensure staff are in mandatory trainings and certifications for ADA (Adaptive De-Escalation</p>	V 133		

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V 133	<p>Continued From page 101</p> <p>Alternatives)."</p> <p>-He (Licensee) is present, he has been here a couple of times with the kids ..."</p> <p>-For HCPR checks, " ...We have an individual at the office who does it but I am supposed to follow up that it's done as I am the supervisor ... I don't know her name, she is at the main office so I don't want to lie about names."</p> <p>-The same person responsible for completing HCPR checks was responsible for completing the criminal history record checks.</p> <p>-In regard to the items not being in the file, "I am in the loop and have been told ..."</p> <p>Interview on 4-19-23 with the Licensee revealed:</p> <p>-"I've been keeping up personnel records currently, but we are bringing in a person to do it on a daily basis."</p> <p>-In the meantime, "I will be responsible."</p> <p>-"That would be the person I bring on board. I have been doing it." (person responsible for completing HCPR and background checks)</p> <p>-Stated that he did not have a file, " ...(I'm) here for strictly business and don't get involved in incidents and stuff going on here."</p> <p>-He did not have any personnel records for himself except for the HCPR check dated 12-1-22.</p> <p>This deficiency is cross referenced into 10A NCAC 27E .0101 Least Restrictive Alternative (V513) for a Type A1 rule violation and must be corrected within 23 days.</p>	V 133		
V 138	<p>27G .0404 (A-E) Operations During Licensed Period</p> <p>10A NCAC 27G .0404 OPERATIONS DURING LICENSED PERIOD</p>	V 138		

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V 138	<p>Continued From page 102</p> <p>(a) An initial license shall be valid for a period not to exceed 15 months from the date on which the license is issued. Each license shall be renewed annually thereafter and shall expire at the end of the calendar year.</p> <p>(b) For all facilities providing periodic and day/night services, the license shall be posted in a prominent location accessible to public view within the licensed premises.</p> <p>(c) For 24-hour facilities, the license shall be available for review upon request.</p> <p>(d) For residential facilities, the DHSR complaint hotline number shall be posted in a public place in each facility.</p> <p>(e) A facility shall accept no more clients than the number for which it is licensed.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that it would serve no more clients than the number for which it was licensed affecting 4 of 5 current Clients (#1-#4) and 3 of 4 Former Clients (FC #6-#8). The findings are:</p> <p>Review on 4-11-23 of the facility's license issued by the Division of Health Service Regulation (DHSR) valid through 12-31-23 revealed: -Residential capacity of 6.</p> <p>Review on 4-12-23 of a form titled "Pinnacle Therapeutic Service Monthly Headcount Sheet March 2023" provided by the Licensee on 4-12-23 revealed: -From 3-2-23 to 3-11-23 there were a total of 7</p>	V 138		

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V 138	<p>Continued From page 103</p> <p>clients admitted to the facility.</p> <p>Interview on 4-17-23 with the Qualified Professional (QP)/Program Director (PD) revealed:</p> <p>- "The only days we count for an individual is when they are asleep in the bed. We didn't count her (Client #4) ... They are in the hospital at that time so we don't bill for the time they are at the hospital."</p> <p>- "She (Client #4) would still be under our care, but the decisions that would be made come from her legal guardian so we didn't discharge her and we still keep in contact with the legal guardian."</p> <p>- "No, We have never gone over 6."</p> <p>- "Oh wait, the reason [Former Client (FC) #8] came was because it was going to only be for a 10 day stay and we spoke with the legal guardian of [Client #4] and she (Client #4) was still at the hospital so it was okay for us to do the 10 day stay for [FC #8]."</p> <p>- "I should have done a discharge before I accepted a 10 day stay."</p> <p>Interview on 4-19-23 with the Licensee revealed:</p> <p>- "... Technically because we didn't discharge or do a proper discharge with [Client #4] that we shouldn't have put another client in that bed."</p> <p>This deficiency is cross referenced into 10A NCAC 27E .0101 Least Restrictive Alternative (V513) for a Type A1 rule violation and must be corrected within 23 days.</p>	V 138		
V 272	<p>27G .5101 Community Respite - Scope</p> <p>10A NCAC 27G .5101 SCOPE</p> <p>(a) Community respite is a service which provides periodic relief for a family or family</p>	V 272		

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V 272	<p>Continued From page 104</p> <p>substitute on a temporary basis. While overnight care is available, community respite services may be provided for periods of less than 24 hours on a day or evening basis. Respite care may be provided by the following models:</p> <p>(1) Center-based respite - the individual is served at a designated facility. While an overnight capacity is generally a part of this service, a respite center may provide respite services to individuals for periods of less than 24 hours on a day or evening basis.</p> <p>(2) Private home respite - the individual is served in the provider's home on an hourly or overnight basis.</p> <p>(b) Private home respite services serving individuals are subject to licensure under G.S. 122C, Article 2 when:</p> <p>(1) more than two individuals are served concurrently; or</p> <p>(2) either one or two children, two adults, or any combination thereof are served for a cumulative period of time exceeding 240 hours per calendar month.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to operate within the scope of their license affecting 5 of 5 current clients (Clients #1-#5) and 2 of 4 former clients (Former Clients (FC) #6 and #7). The findings are:</p> <p>Review on 4-12-23 of Client #1's record revealed: -Age: 16 years old. -Date of admission 2-24-23. -Diagnoses: Attention Deficit Hyperactivity Disorder (ADHD); Disruptive Mood Dysregulation; Post Traumatic Stress Disorder (PTSD); Conduct Disorder; Unspecified Personality Disorder. -Served at the facility for 48 days as of 4-12-23.</p>	V 272		

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V 272	<p>Continued From page 105</p> <p>Review on 4-12-23 of Client #2's record revealed: -Age: 16 years old. -Date of Admission: 2-21-23. -Diagnoses: Per local hospital discharge summary dated 2-21-23 Bipolar Disorder, Rare Mixed with Psychotic Effects; PTSD; Rule Out (R/O) ADHD; Oppositional Defiant Disorder (ODD); Cluster B Personality Traits. -Served at the facility for 51 days as of 4-12-23.</p> <p>Review on 4-12-23 of Client #3's record revealed: -Age: 12 years old. -Date of Admission: 3-1-23. -Diagnoses: -Per local hospital document dated 2-15-23 Disruptive Mood Dysregulation Disorder. -Per application dated 3-1-23 ODD, Moderate; ADHD; PTSD. -Served at the facility for 43 days as of 4-12-23.</p> <p>Review on 4-12-23 of Client #4's record revealed: -Age: 15 years old. -Date of Admission: 2-23-23. -Diagnoses: Not identified in the record. -Served at the facility for 49 days as of 4-12-23.</p> <p>Review on 4-19-23 of Client #5's record revealed: -Age: 16 years old -Date of Admission: 4-10-23. -Diagnoses: Conduct Disorder. -No evidence of assessments as appropriate to the client's needs. -Comprehensive Clinical Assessment (CCA) dated 4-10-23 and faxed to the provider on 4-12-23 (per fax transmittal cover sheet by legal guardian) indicated a history of "suicidal remarks, self-harm and aggressive behaviors ...when she feels her independence is threatened, she will either lash out physically or run away ...Due to</p>	V 272		

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V 272	<p>Continued From page 106</p> <p>client behaviors including elopement, her team has had difficulty locating long term placement ...Client has a significant trauma history including physical abuse, sexual abuse and reportedly human trafficking. Client is also currently on probation ...Client takes minimal responsibility for her choices and has shown little insight into her choices and related concerns for her safety ...She continues to be at risk unless placed under close 24/7 supervision given her frequent elopement and history of trafficking. Placement at a PRTF (Psychiatric Residential Treatment Facility) ...DJJ (Department of Juvenile Justice) documentation indicates that client has run away numerous times and has been passed around for sex by adult men while she was on the run ..."</p> <p>Review on 4-12-23 of FC #6's record revealed: -Age: 15 years old. -Date of Admission: 2-15-23. -Date of Discharge: 3-31-23 (Not identified in the record but identified on the client roster sheet completed by the Licensee at the start of the survey). -Diagnoses: Not identified in the record. -Served at the facility for 42 days.</p> <p>Review on 4-12-23 of FC #7's record revealed: -Age: 15 years old. -Date of Admission: 2-19-23. -Date of Discharge: Not identified in the record. -Diagnoses: Per application dated 2-19-23 ADHD; PTSD. -Served at the facility for 54 days.</p> <p>Review on 4-12-23 of Law Enforcement Report dated 4-7-23 regarding FC#7 revealed: -Client ran away from the facility on 4/7/23.</p> <p>During the survey, FC#7 never returned to the</p>	V 272		

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V 272	<p>Continued From page 107</p> <p>facility.</p> <p>Interview on 4-18-23 with Client #5's guardian revealed: -Was not sure how long Client #5 would be at the facility, "...waiting for an admission date to a PRTF."</p> <p>Interview on 4-19-23 with Staff #2 revealed: -Staff #3 asked Client #5 to go to the convenience store to get flour. -"...Me and [Staff #3] were looking out the window and I think somebody picked her (Client #5) up because she had a cell phone..." -"We (Staff #2 and #3) watched her (Client #5) walk across the street and she disappeared..."</p> <p>Interview on 4-17-23 with the Qualified Professional/Program Director revealed: -FC #7 was discharged after she ran away. " ...When she ran away (on 4-7-23), we did discharge that Monday (4-10-23)." -Stated clients would remain at the facility for 90 days or less. -Would rely on the Social Worker to determine length of placement. -Was unaware that Client #2 was going to be at the facility for more than 30 days.</p>	V 272		
V 366	<p>27G .0603 Incident Response Requirments</p> <p>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</p>	V 366		

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V 366	<p>Continued From page 108</p> <p>of individuals involved in the incident;</p> <p>(2) determining the cause of the incident;</p> <p>(3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;</p> <p>(4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;</p> <p>(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;</p> <p>(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</p> <p>(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.</p> <p>(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.</p> <p>(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:</p> <p>(1) immediately securing the client record by:</p> <p>(A) obtaining the client record;</p> <p>(B) making a photocopy;</p> <p>(C) certifying the copy's completeness; and</p> <p>(D) transferring the copy to an internal review team;</p> <p>(2) convening a meeting of an internal review team within 24 hours of the incident. The</p>	V 366		

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V 366	<p>Continued From page 109</p> <p>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:</p> <p>(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;</p> <p>(B) gather other information needed;</p> <p>(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</p> <p>(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</p> <p>(3) immediately notifying the following:</p> <p>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;</p> <p>(B) the LME where the client resides, if different;</p> <p>(C) the provider agency with responsibility</p>	V 366		

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V 366	<p>Continued From page 110</p> <p>for maintaining and updating the client's treatment plan, if different from the reporting provider;</p> <p>(D) the Department;</p> <p>(E) the client's legal guardian, as applicable; and</p> <p>(F) any other authorities required by law.</p> <p>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 or III incidents. The findings are:</p> <p>Refer to V367 for specific details of each incident and to V123 for details of medication errors.</p> <p>Review on 4-12-23 of Client #1's record revealed: -Age: 16 years old. -Date of admission 2-24-23. -Diagnosis: Attention Deficit Hyperactivity Disorder (ADHD); Disruptive Mood Dysregulation; Post Traumatic Stress Disorder (PTSD); Conduct Disorder; Unspecified Personality Disorder.</p> <p>Review on 4-12-23 of Client #2's record revealed: -Age: 16 years old. -Date of Admission: 2-21-23. -Diagnoses: Per local hospital discharge summary dated 2-21-23 Bipolar Disorder, Rare Mixed with Psychotic Effects; PTSD; Rule Out (R/O) ADHD; Oppositional Defiant Disorder (ODD); Cluster B Personality Traits.</p>	V 366		

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V 366	<p>Continued From page 111</p> <p>Review on 4-12-23 of Client #3's record revealed: -Age: 12 years old. -Date of Admission: 3-1-23. -Diagnoses: -Per local hospital document dated 2-15-23 Disruptive Mood Dysregulation Disorder. -Per application dated 3-1-23 ODD, Moderate; ADHD; PTSD.</p> <p>Review on 4-12-23 of Client #4's record revealed: -Age: 15 years old. -Date of Admission: 2-23-23. -Diagnoses: Not identified in the record.</p> <p>Review on 4-19-23 of Client #5's record revealed: -Age: 16 years old. -Date of Admission: 4-10-23. -Diagnoses: Conduct Disorder.</p> <p>Review on 4-12-23 of FC #6's record revealed: -Age: 15 years old. -Date of Admission: 2-15-23. -Date of Discharge: Not identified in the record. -Diagnoses: Not identified in the record.</p> <p>Review on 4-12-23 of FC #7's record revealed: -Age: 15 years old. -Date of Admission: 2-19-23. -Date of Discharge: Not identified in the record. -Diagnoses: Per application dated 2-19-23 ADHD; PTSD.</p> <p>Reveiw on 4-18-23 of the facility's "Policies and Procedures Revised 12/22" revealed: -"Incidents... Procedures: ...5) Level II Incidents... b. These incidents require communication between the provider and the managed care organization (MCO), documentation of the</p>	V 366		

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V 366	<p>Continued From page 112</p> <p>incident, and a report to the MCO and other authorities as required by law. Level II incidents must be reported in IRIS (Incident Reporting and Improvement System) ...6) Level III Incidents...</p> <p>b. These incidents require communication among the provider, MCO, and DHSR (Division of Health Service Regulation), documentation of the incident, and a report to the MCO, DHSR, and other authorities as required by law. Level III incidents must be reported in IRIS..."</p> <p>Review on 4-13-23 of the facility's internal incident reports for February 2023 through April 2023 revealed: -No documented incident reports for medication errors. -No documentation of a response attending to the health and safety needs of the clients, determining the cause of the incidents, developing and implementing corrective measures to prevent similar incidents, assigning personnel to be responsible for implementation of the corrections for preventative measures, and maintain the necessary documentation of these items.</p> <p>Review on 4-11-23 and 4-19-23 of IRIS revealed: -No IRIS report, Risk/Cause Analysis, or documentation to support submission of written preliminary findings of fact to the Local Management Entity (LME)/Managed Care Organization (MCO) within 5 working days for incidents which occurred on 2-24-23, 3-4-23, 3-6-23, 3-9-23, 3-11-23, 3-14-23, 3-15-23, 3-20-23, 3-22-23, 3-29-23, 3-30-23, 3-31-23, 4-2-23, 4-7-23, 4-10-23, 4-11-23, 4-12-23, 4-14-23 and 4-18-23.</p> <p>Interview on 4-17-23 with the Qualified</p>	V 366		

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V 366	<p>Continued From page 113</p> <p>Professional (QP)/Program Director (PD) revealed: -He was "ultimately responsible" for incident reports. -Facility staff were required to fill out an incident report if a client refused 3 doses of medication. -Incident reports had not been completed for any law enforcement responses to the facility. -" ...we have been informed that any time a police officer is called, we need to have it documented, and we will start that tracking ..." -" ...I have a couple of incident reports that didn't get in the system (IRIS) ...I missed that and it's the first place it needs to go. I dropped the ball on that ..." -" ...I need to do a better job with the investigation and documentation piece ..."</p> <p>Interview on 4-19-23 with the Licensee revealed: -" ...if they (clients) refuse (medications) I think we need to do an incident report, so I rescheduled the training with a certified nurse and issues of when to give it (medication) and when not ..." -He was aware of the allegation made by FC #6 against the QP/PD. -He was aware of the allegation made by Client #4 against Client #2. -He was aware Client #3 was "being erratic" on 4-10-23 and the police were at the facility. " ...I'm pretty sure we talked about completing one (incident report for 4-10-23) ... I understand what we aren't doing, and I will brush up on that ...we will discuss that, and I understand IRIS will capture everything for us more than our documentation and I will ensure we do that process ..."</p> <p>This deficiency is cross referenced into 10A NCAC 27E .0101 Least Restrictive Alternative</p>	V 366		

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V 366	Continued From page 114 (V513) for a Type A1 rule violation and must be corrected within 23 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 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	V 367		

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V 367	<p>Continued From page 115</p> <p>erroneous, misleading or otherwise unreliable; or</p> <p>(2) the provider obtains information required on the incident form that was previously unavailable.</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(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).</p> <p>(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:</p> <p>(1) medication errors that do not meet the definition of a level II or level III incident;</p> <p>(2) restrictive interventions that do not meet the definition of a level II or level III incident;</p> <p>(3) searches of a client or his living area;</p> <p>(4) seizures of client property or property in the possession of a client;</p> <p>(5) the total number of level II and level III incidents that occurred; and</p>	V 367		

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V 367	<p>Continued From page 116</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report all level II and III incidents to the Local Management Entity (LME)/Managed Care Organization (MCO) as required within 72 hours of becoming aware of the incident. The findings are:</p> <p>Review on 4-13-23 of the facility's internal incident reports for February 2023 through April 2023 revealed: -2-24-23 at 8:45 pm " ... [Client #4] stated on 2-22-23 one of her male house peers (not identified in the report) touched her without her consent ...they had intercourse while she was in his bedroom without her consent ..." 3-30-23 at 6:30 pm physical altercation between the Qualified Professional/Program Director (QP/PD) and Former Client (FC) #6 4-2-23 at 5:45 pm law enforcement responded in reference to " ... [Client #4] ...trying to ...harm to peers/staff with knife, broken glass ..." -4-7-23 at 3:40 pm FC #7 broke glass, caused a fire hazard and eloped from the facility.</p> <p>Review on 4-19-23 of the Local Police</p>	V 367		

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V 367	<p>Continued From page 117</p> <p>Department Incident/Investigation Reports dated 3-9-23 to 4-18-23 revealed:</p> <p>-3-9-23 at 9:33 pm law enforcement responded "for a report of male juveniles (Client #2 and FC #6) involved in a physical altercation ..."</p> <p>-3-11-23 at 1:57 pm law enforcement responded to a physical fight between FC #6 and FC #8.</p> <p>-3-14-23 at 1:55 pm law enforcement responded "in reference to a report of disorderly conduct (Client #3 attempted to steal a vehicle) ..."</p> <p>-4-2-23 at 5:59 pm law enforcement responded "in reference to a suicidal subject (Client #4) ..."</p> <p>-4-7-23 at 11:55 pm law enforcement responded "in reference to serving involuntary commitment (IVC) papers" on FC #7 and upon arriving, law enforcement discovered FC #7 had eloped from the facility.</p> <p>-4-10-23 at 10:13 pm law enforcement responded "in reference to a runaway (Client #3) ..."</p> <p>-4-11-23 at 1:03 pm law enforcement responded "in reference to a juvenile (Client #4) acting disorderly ..."</p> <p>-4-12-23 at 5:02 pm law enforcement responded "in reference to a civil disturbance (Client #4 attempted to damage property) ..."</p> <p>-4-12-23 at 8:26 pm law enforcement responded "in reference to serving involuntary commitment papers" on Client #4 and upon arriving, law enforcement discovered Client #4 had eloped from the facility.</p> <p>-4-14-23 at 3:39 am law enforcement responded in reference to "...Caller (FC #7) ...had several items stolen from this location (Pinnacle Therapeutic Services) ..."</p> <p>-4-18-23 at 10:16 pm law enforcement responded "in reference to a runaway (Client #5) ..."</p> <p>Review on 4-12-23 of the Local Police Department Computer-Aided Dispatch (CAD) report dated 4-12-23 revealed:</p>	V 367		

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V 367	<p>Continued From page 118</p> <p>-19 law enforcement calls for service to Pinnacle Therapeutic Services from 2/24/23 through 4/11/23.</p> <p>-Calls included the following:</p> <ul style="list-style-type: none"> -2-24-23 at 10:24 pm in reference to "Assist Another Agency ...Have a female subject (not identified in CAD report) feeling suicidal ..." -3-4-23 at 5:23 pm in reference to a "Civil Disturbance ...2nd call this location ...altercation between 15 y/o (year old) and 16 y/o (individuals not identified in CAD report) ..." -3-6-23 at 8:35 pm in reference to a "Civil Disturbance ...caller states one of the youth (FC #7) has ran away ..." -3-15-23 at 2:00 pm in reference to a "Health Check ...Resident (Client #4) wants to move out ...Stated social worker and staff won't help her ..." -3-20-23 at 5:26 pm in reference to "Damage to Property ... [FC #6] picking up wooden pavers ...and was hitting staff's vehicle ..." -3-22-23 at 12:17 am in reference to a "Property Check (no details provided)." -3-29-23 at 7:23 pm in reference to " ...one of the juveniles (not identified in CAD report) was attempting to fight with the staff ..." -3-31-23 at 3:41 pm in reference to IVC " ... [Client #1] ...is combative and refusing to take her medicine ..." <p>Review on 4-11-23 and 4-19-23 of the North Carolina Incident Response Improvement System (IRIS) revealed:</p> <ul style="list-style-type: none"> -No IRIS report, Risk/Cause Analysis, or documentation to support submission of written preliminary findings of fact to the LME/MCO within 5 working days for incidents which occurred on 2-24-23, 3-4-23, 3-6-23, 3-9-23, 3-11-23, 3-14-23, 3-15-23, 3-20-23, 3-22-23, 3-29-23, 3-30-23, 3-31-23, 4-2-23, 4-7-23, 4-10-23, 4-11-23, 4-12-23, 4-14-23 and 4-18-23. 	V 367		

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V 367	<p>Continued From page 119</p> <p>Interview on 4-17-23 with the QP/PD revealed: -He was "ultimately responsible" for incident reports. -Incident reports had not been completed for any law enforcement responses to the facility. -" ...we have been informed that any time a police officer is called, we need to have it documented, and we will start that tracking ..." -" ...I have a couple of incident reports that didn't get in the system (IRIS) ...I missed that and it's the first place it needs to go. I dropped the ball on that ..." -" ...I need to do a better job with the investigation and documentation piece ..."</p> <p>Interview on 4-19-23 with the Licensee revealed: -He was aware of the allegation made by FC #6 against the QP/PD. -He was aware of the allegation made by Client #4 against Client #2. -He was aware Client #3 was "being erratic" on 4-10-23 and the police were at the facility. " ...I'm pretty sure we talked about completing one (incident report for 4-10-23) ... I understand what we aren't doing, and I will brush up on that ...we will discuss that, and I understand IRIS will capture everything for us more than our documentation and I will ensure we do that process ..."</p> <p>This deficiency is cross referenced into 10A NCAC 27E .0101 Least Restrictive Alternative (V513) for a Type A1 rule violation and must be corrected within 23 days.</p>	V 367		
V 500	<p>27D .0101(a-e) Client Rights - Policy on Rights</p> <p>10A NCAC 27D .0101 POLICY ON RIGHTS</p>	V 500		

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V 500	<p>Continued From page 120</p> <p>RESTRICTIONS AND INTERVENTIONS</p> <p>(a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66.</p> <p>(b) The governing body shall develop and implement policy to assure that:</p> <p>(1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and</p> <p>(2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications.</p> <p>(c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies:</p> <p>(1) any restrictive intervention that is prohibited from use within the facility; and</p> <p>(2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client.</p> <p>(d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify:</p> <p>(1) the permitted restrictive interventions or allowed restrictions;</p> <p>(2) the individual responsible for informing the client; and</p> <p>(3) the due process procedures for an involuntary client who refuses the use of restrictive interventions.</p> <p>(e) If restrictive interventions are allowed for use</p>	V 500		
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V 500	<p>Continued From page 121</p> <p>within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes:</p> <p>(1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E);</p> <p>(2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and</p> <p>(3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure all instances of alleged abuse were reported to the local Department of Social Services (DSS) affecting 1 of 5 current Clients (Client #4) and 1 of 4 Former Clients (FC #6). The findings are:</p> <p>Refer to V132 for specific details regarding the allegation of abuse.</p> <p>Review on 4-12-23 of Client #4's record revealed: -Age: 15 years old. -Date of Admission: 2-23-23. -Diagnoses: Not identified in the record.</p> <p>Review on 4-12-23 of FC #6's record revealed: -Age: 15 years old.</p>	V 500		

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V 500	<p>Continued From page 122</p> <p>-Date of Admission: 2-15-23. -Date of Discharge: Not identified in the record. -Diagnoses: Not identified in the record.</p> <p>Review on 4-13-23 of Staff #1's personnel record revealed: -No evidence of date of hire. -No evidence of job title.</p> <p>Review on 4-13-23 of the Qualified Professional/Program Director (QP/PD) Personnel Record revealed: -Date of Hire: not identified in the record. -Job Title: QP/PD -Certificate of Training titled "Identifying and Responding to Child Abuse and Neglect" dated 6-1-22.</p> <p>Review on 4-19-23 of the Local Police Department Incident/Investigation Report dated 4-11-2 revealed: -4-11-23 at 1:03 pm law enforcement responded " ...Client #4] advised that she was upset because [Staff #1] had made her cry earlier ...that [Staff #1] yelled at her ...then shoved her ..."</p> <p>Review on 4-13-23 of the facility's internal incident reports from February 2023 through April 2023 revealed: -On 3-30-23 " ...As staff (QP/PD) stood at the top of the stairs [FC #6] came out of his bedroom cussing and threaten to kick staff a*s if I (QP/PD) did not go back downstairs. [FC #6] approached and pushed staff (QP/PD) then started pointing his finger in staff 's (QP/PD's) face making contact, while making statements that he (FC #6) was going to kick staff's (QP/PD's) a*s because staff (QP/PD) feared him. Staff (QP/PD) requested [FC #6] to stop and return to his bedroom ... [FC #6] continues to demonstrate</p>	V 500		

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V 500	<p>Continued From page 123</p> <p>aggressive behavior by pushing staff (QP/PD) for the second time, but with more aggression. Staff (QP/PD) started falling down the stairs after the second push from [FC #6]. The staff's (QP/PD's) natural reaction was to grab something to prevent me (QP/PD) from falling from the top of the stairs to the bottom. Staff (QP/PD) grabbed [FC #6] and both of us went falling down the stairs. Once we reached the bottom of the stairs [FC #6] continued to assault staff (QP/PD). Staff (QP/PD) extended his right arm and placed it on [FC #6] chest/neck area to prevent him from grabbing me (QP/PD). Another youth (Client #2) intervened by grabbing [FC #6] to help de-escalate the situation ..."</p> <p>-No documentation of an "allegation of abuse" against the QP/PD made by FC #6.</p> <p>-No incident report for 4-11-23.</p> <p>-No documentation of an allegation of abuse against Staff #1 made by Client #4 on 4-11-23.</p> <p>-No documentation that either allegation of abuse was reported to the local DSS.</p> <p>Interview on 4-12-23 with Client #4 revealed: -"I got pushed by [Staff #1] yesterday in the office..."</p> <p>Interview on 4-13-23 with Staff #1 revealed: -She (Client #4) said I touched her and that I hit her, but all I did was walk past her ..."</p> <p>Interview on 4-11-23 with Client #3 revealed: -She had observed the QP/PD abusing FC #6.</p> <p>Interviews on 4-11-23 and 4-12-23 with Client #4 revealed: -She had observed the QP/PD abusing FC #6.</p> <p>Interview on 4-17-23 with QP/PD revealed: -" ...[FC #6] came out of his bedroom and started</p>	V 500		

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V 500	<p>Continued From page 124</p> <p>yelling and pushed me and he pushed me down one step ...I felt like I was falling down the steps and my first reaction was to grab the first thing which was him (FC #6) ...[Client #1] said, '[QP/PD] you're choking him.' I wasn't choking him ..."</p> <p>Interview on 4-19-23 with the Licensee revealed: -Did not understand the protocol of reporting allegations against staff to DSS.</p> <p>This deficiency is cross referenced into 10A NCAC 27E .0101 Least Restrictive Alternative (V513) for a Type A1 rule violation and must be corrected within 23 days.</p>	V 500		
V 512	<p>27D .0304 Client Rights - Harm, Abuse, Neglect</p> <p>10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION</p> <p>(a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66.</p> <p>(b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter.</p> <p>(c) Goods or services shall not be sold to or purchased from a client except through established governing body policy.</p> <p>(d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter.</p>	V 512		

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V 512	<p>Continued From page 125</p> <p>(e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, 2 of 11 Paraprofessional Staff (Staff #2 and Staff #4) and 1 of 1 Qualified Professional/Program Director (QP/PD) neglected 1 of 5 clients (Client #3). The findings are:</p> <p>Review on 4-12-23 of Client #3's record revealed: -Age: 12-years old. -Sex: female. -Date of Admission: 3-1-23. -Date of Discharge: 4-13-23. -Diagnoses: -Per local hospital document dated 2-15-23 Disruptive Mood Dysregulation Disorder. -Per application dated 3-1-23 Oppositional Defiant Disorder, Moderate; Attention Deficit Hyperactivity Disorder; Post Traumatic Stress Disorder.</p> <p>Review on 4-13-23 of Staff #2's personnel record revealed: -Date of Hire: not identified in the record. -No evidence of training to meet the mental health /developmental disabilities/substance abuse (mh/dd/sa) needs of the clients as specified in the treatment/habilitation plan.</p> <p>Review on 4-13-23 of Staff #4's personnel record revealed: -Date of Hire: not identified in the record. -No evidence of training to meet the mental</p>	V 512		

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V 512	<p>Continued From page 126</p> <p>health /developmental disabilities/substance abuse (mh/dd/sa) needs of the clients as specified in the treatment/habilitation plan.</p> <p>Review on 4-13-23 of the QP/PD's personnel record revealed: -Date of Hire: not identified in the record. -Certificate of Training titled "Identifying and Responding to Child Abuse and Neglect" dated 6-1-22.</p> <p>Observation on 4-17-23 at 11:00 am of the roadway directly outside of the facility revealed: -The facility is located on a 5-lane road (two lanes each direction with a center turn lane). -The speed limit was 45 miles per hour. -There were no sidewalks nor crosswalks on either side of the road in the vicinity of the facility.</p> <p>Review on 4-12-23 of local police department incident/investigation report dated 4-10-23 revealed: -Law Enforcement responded to the facility on 4-10-23 at 10:13 pm in reference to a runaway. -"Upon arrival, I (local law enforcement officer (LEO)) located the runaway [Client#3]...walking in the roadway in front of Pinnacle Therapeutic Services...she (Client #3) advised she didn't want to be in the home...[QP/PD] stepped outside. Once [Client #3] saw [QP/PD], she became irate and upset and threw her slushie at [QP/PD]. [Client #3] stated 'That's for choking me.' [Client #3] advised [QP/PD] had choked her earlier..." -"...He (the QP/PD) was going to try and seek involuntary commitment (IVC) paperwork on [Client #3]. I (LEO) suggested he transported [Client #3] to the hospital himself or by ambulance since she is a juvenile in his custody. [QP/PD] advised he would not transport her (Client #3) due to her aggressiveness and was</p>	V 512		

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V 512	<p>Continued From page 127</p> <p>not going to allow her back in the house for safety reasons..."</p> <p>-Client #3 "wanted to go back to her room...the employee (staff) shut the door and locked it on me (LEO) and [Client #3]."</p> <p>-"...I (LEO) knocked on the door to advise the employees (Staff #2 and #4) officers and I were leaving and remind them that [Client 3] was in their custody. The employees ignored my knocking and walked into another room...I advised the employees [Client #3] was attempting to get back into her room through a different door in hopes one of her roommates would open the door for her..."</p> <p>Review on 4-18-23 of local police department body camera video footage dated 4-10-23 and time stamped 10:24 pm to 11:07 pm revealed:</p> <p>-10:25pm LEOs arrived at Pinnacle Therapeutic Services. Client #3 was observed walking on the road. LEOs removed Client #3 from the road and escorted Client #3 to the facility property.</p> <p>-The QP/PD stated "...you're (Client #3) not going back in there" (into facility.)</p> <p>-10:26 pm the QP/PD went inside the facility.</p> <p>-10:34 pm Client #3 was wearing a short sleeve shirt, plaid pajama pants and open-toed slide sandals and no socks.</p> <p>-10:36 pm LEO stated to Client #3 "There are people on these streets that will hurt you."</p> <p>-10:38 pm LEO knocked on the front door of the facility. The QP/PD stepped out to speak with LEOs and stated he was getting the house settled and was "...going to do the (IVC) paperwork to make sure she (Client #3) gets in (committed) for the next 7 days". The QP/PD went back inside the facility and shut the door and left LEOs outside with Client #3.</p> <p>-10:46 pm LEO knocked on the front door of the facility and the QP/PD opened the door and</p>	V 512		

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V 512	<p>Continued From page 128</p> <p>stepped outside.</p> <p>-LEO asked "What's y'all's plan? If you want to take her (Client #3) to the hospital, she's a juvenile, she has to go."</p> <p>-QP/PD replied "Yeah, I'm going to do the IVC paperwork. I was just finishing giving the meds (medications) because all this happened in the middle of giving meds...I'm going to the magistrate's office."</p> <p>-LEO stated "...I don't see why we can't call an ambulance and y'all take her because she would have to go regardless. And then when she gets checked out, if they need to IVC her they can do that paperwork. If that makes sense to you."</p> <p>-The QP/PD responded, "Say that again."</p> <p>-LEO stated "Instead of (going to magistrate) straight to the IVC paperwork, she (Client #3) would have to go to the hospital with y'all. She's a juvenile, so once she's checked out (evaluated) they (hospital staff) would determine if she needs to be IVC'd and they would issue that paperwork. If that makes sense."</p> <p>-The QP/PD replied, "Ok if she's not IVC'd you saying they would send her back here?"</p> <p>-LEO stepped away to speak to the other LEOs on site .</p> <p>-10:49 pm LEO knocked on the front door of the facility. The QP/PD stepped outside. LEO explained to him that if an ambulance was called Client #3 would have to go to the hospital and be evaluated. If it was determined for her to be IVC'd, the hospital would complete the paperwork. LEO offered to call the ambulance for Client #3. The QP/PD replied, "Yeah we can do that."</p> <p>-10:53 pm LEO informed the QP/PD that another option was for the QP/PD to transport Client #3 to the hospital. The QP/PD refused to transport Client #3 due to her aggression towards him.</p> <p>-LEO repeated "She's in y'all's custody. If y'all</p>	V 512		

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V 512	<p>Continued From page 129</p> <p>want to drive her to the hospital you can." -The QP/PD responded "Nah, not after she done assault me, I'm not gonna be like that with her cause aggressiveness towards me as you just seen with the drink. And so, It was double that within the house. So, I refuse to transport her." -LEO could be heard talking on the phone stating "He's refusing to transport her." -The QP/PD stated, "Because of the aggressiveness towards me." -10:54 pm LEO stated, "If you want to call an ambulance y'all can but one of y'all obviously have to ride with her because she is in your custody." -The QP/PD stated "alright but I can just go ahead and do the IVC because I refuse, to bring I know what's going on and I refuse to bring that back in the house knowing that it's a safety issue if she's here. So, I would like to go the IVC route." -LEO could be heard talking on the phone stating "He wants to IVC her because he doesn't want her in the house." -The QP/PD stated, "Because I already know it's unsafe right now." -10:55 pm LEO could be heard speaking on the phone "She (Client #3) keeps trying to leave the property...the reason he (the QP/PD) wants to IVC her is so that she's out of the house cause she threw a drink at him and he's all mad about that now. She claimed that he choked her and that's why she's upset right now ..." -11:00 pm Client #3 walked up a set of stairs on the outside of the back of the facility. While knocking on the door at the top of the stairs, Client #3 touched a broken windowpane with jagged glass. -11:01 pm LEO encouraged Client #3 " ... We can go to the front and see if they'll open the door for us. I don't know if anyone is going to open those</p>	V 512		

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V 512	<p>Continued From page 130</p> <p>doors. Why don't we try up front...Let's try this front door. It's a little chilly out here."</p> <p>-11:02 pm LEOs could be heard stating that the QP/PD had left the facility.</p> <p>-11:03 pm Client #3 and LEOs walked to the front of the facility.</p> <p>-LEO "Let's see if someone will answer this door" and knocked on the front door.</p> <p>-Client #3 tried to open the front door and it was locked.</p> <p>-Staff opened the door and LEO informed staff "She's (Client #3) in y'all's custody."</p> <p>-Staff responded "Who, who said that?"</p> <p>-LEO advised that Client #3 was not in the custody of LEOs.</p> <p>-Staff responded, "I need to speak to my supervisor."</p> <p>-LEO asked "...she (Client #3) is staying here, so you are refusing?"</p> <p>-Staff did not respond to LEO and shut the door while LEO was speaking.</p> <p>-11:04 pm Client #3 stated "This is why I don't want to be here because of this...I should have killed myself when I had the chance."</p> <p>-11:04 pm LEO was heard on phone. "...She (Client #3) is trying...to go into her bedroom and the employees (staff) opened the door and I said she's in y'all's custody, she'd like to go in. She (staff) said no who said that, no she ain't and she closed the door and locked it on me....the employee did...(LEO was still on the phone but not speaking and Client #3 walked off the front porch and around to the stairs on the front of the house leading to second floor.)</p> <p>-11:05 pm Banging could be heard, and LEO instructed Client #3 to "Keep banging on the doors to get your friends to open up." Client #3 replied "ok." Staff could be seen walking around inside the facility.</p> <p>-11:05 pm LEO was knocking on the front door of</p>	V 512		

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V 512	<p>Continued From page 131</p> <p>the facility. The door was closed, and LEO was yelling through the closed door to two female staff who were visible inside the facility. (Front door is a glass window panel door with 3 rows across and 5 panes in length.) "Hey, we're leaving and if something happens to her (Client #3) it's on y'all so she's here. She's trying to get into her bedroom. So, we're leaving." Officer starts to walk away from door. Staff were visible behind the closed door. -11:06 pm LEO stated to other officer on site "I'm going to say something one more time." -LEO returned to the front door. There are two staff and a client standing on the other side of the door. -(The door was closed) LEO stated "did you hear me. Did you hear me? She's (Client #3) in your custody and if something happens to her, the 12-year-old girl is in your custody so we are leaving. She is gonna try and get into her bedroom I guess." (Staff unlocks door, you can hear the lock click. The staff member opened the door and did not speak but tried to hand the LEO the phone.) -LEO stated to staff "I don't need to speak to them. I'm talking to y'all who are here." -Staff said "ok." -LEO - "He's (QP/PD) at the magistrate now. She (Client #3) is in your custody. We're leaving so if something happens to her. (staff said 'ok'). She's a 12-year-old girl. She's trying to get into her bedroom so she can go to bed. Again, she is in your custody. But we're leaving." (LEO turns and walks away.) -11:07 pm LEO said to Client #3 "...keep knocking to see if your friends will open." Client #3 replied "ok." -Client #3 had outbursts of crying and screaming throughout the video. -There was no evidence of any staff being</p>	V 512		

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V 512	<p>Continued From page 132</p> <p>present outside to monitor Client #3 during the entirety of the body camera footage.</p> <p>Review on 4-18-23 of local police department body camera video footage dated 4-10-23 and time stamped 11:40 pm to 11:42 pm revealed: -LEO returned to the facility. -LEO knocked on the front door of the facility and the QP/PD opened the door. -LEO asked the QP/PD "Is she (Client #3) back in here?" and the QP/PD replied "Yes."</p> <p>Review on 4-18-23 of the local weather history revealed: -The temperature in the local area on 4-10-23 dropped to 33 degrees Fahrenheit.</p> <p>Review on 4-13-23 of "Communication Logs for Client Notes" revealed: -No documentation of the incident involving Client #3 dated 4-10-23. -No documentation of Law Enforcement being called to facility on 4-10-23. -4-10-23 "...There were no issues. It was a quiet night." -4-11-23 "Client was not at best behavior today. Clients finally wind down @ 5:15 pm"</p> <p>Review on 4-13-23 of Pinnacle Therapeutic Services Incident Reports revealed: -No incident report for 4-10-23.</p> <p>Review on 4-11-23 and 4-17-23 of the North Carolina Incident Response Improvement System (IRIS) revealed: -No incident documented for the date of 4-10-23.</p> <p>Interview on 4-12-23 with Client #3 revealed: -"Yesterday [QP/PD] choked me. I think he is unfit."</p>	V 512		

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V 512	<p>Continued From page 133</p> <p>- "Yesterday [Staff #2] slammed the door on a police officer. This place is unfit for kids. The police was telling her (Staff #2) that I was in their (Pinnacle Therapeutic Services) care and she slammed the door and locked the door and the police said if something happened to me that I was in the care of this place. I was outside and I only had pants on and no jacket on. I was outside for 20 minutes. I had to bang on windows and the door upstairs and my peers let me in... The staff that locked me out was in the office and was mimicking me..."</p> <p>Interview on 4-11-23 with Client #4 revealed: -The police come to the facility "a lot, a lot." -The police "...came here last night." (4-10-23). -Staff "...wouldn't let her (Client #3) in (the facility)."</p> <p>Interview on 4-18-23 with Staff #2 revealed: -Duties included reading notes from the previous shift. -Worked the evening of 4-10-23 from 8 pm to 8 am with Staff #4. -4-10-23 was Staff #4's first day working at the facility. -Client #3 went Absent Without Official Leave (AWOL) on 4-10-23. -Client #3 was "escalating" and "throwing stuff from upstairs", the QP/PD and Staff #4 went upstairs to try and calm Client #3 down. -Client #3 was smoking "...marijuana or something...she was getting high..." -Client #3 "...came down and packed her stuff and walked out the door..." -The QP/PD called the police. -"He (the QP/PD) said don't let her back in until the police come." -"We were told don't let her back in until the police came and that is the only time she (Client</p>	V 512		

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V 512	<p>Continued From page 134</p> <p>#3) was locked out that I remember." -"When the police got there, we let her in because the police wouldn't take her because they didn't have paperwork from the magistrate. She came in and we did what the police said." -"[Staff #4] opened the door and let her in ..." -"No it wasn't really cold outside" on 4-10-23.</p> <p>Interview on 4-18-23 with Staff #4 revealed: -"I have qualifications of a QP, but I'm working as regular staff (paraprofessional)." -Duties included "ensure safety of client and documentation is completed." -First day of employment was 4-10-23. -Worked with Staff #2 on 4-10-23. -"I believe there was an incident prior to me coming on shift. One of the residents (clients) was having behavioral issues." -The police were called because Client #3 was throwing things down the stairs. -Unsure of the time "...it was after 8 pm. It was dark...I'm not really sure." -Client #3 "...had walked off site...and we let her back in...immediately." -Client #3 was let into the facility. "I prompted one of the clients to open the door for her." -Was not aware that Client #3 had been locked out of the facility.</p> <p>Interview on 4-19-23 with the QP/PD revealed: -Client #3 "...had an outburst. She was outside ...I was outside with her. I went to the magistrate. I asked staff to monitor her. I was outside monitoring her during the outburst. I told staff to monitor her while I went to the magistrate." -"My instructions was for two staff to stand outside and monitor her (Client #3) while she was outside." -It took about 30-45 minutes to process with the magistrate.</p>	V 512		

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V 512	<p>Continued From page 135</p> <p>-The police arrived because they got Client #3 "off the street" and brought her back to the facility property to get her to calm down.</p> <p>-He was told by the police that he couldn't do anything unless the IVC paperwork was signed.</p> <p>-"Police were still here (at the facility) when I left ..."</p> <p>-Staff #2 was outside the facility when he left to go to the magistrate.</p> <p>-Denied that Client #3 was ever locked out of the facility.</p> <p>Interview on 4-19-23 with the Licensee revealed: -"They (staff) called me and said the police were here. There was a skirmish going on. [Client #3] is erratic. [Client #3] was outside trying to get in. Staff (Staff #2) member called me. My exact words 'It is a 12-year-old, let her in the house...'" -"I did instruct her (Staff #2) to open the door and let her (Client #3) in the house."</p> <p>Review on 4-19-23 of the Plan of Protection signed and dated by the Licensee and signed on 4-19-23 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? When a report of abuse, neglect, harm or exploitation is received, the Owner (Licensee)/QP (QP/PD)/QA QI (Quality Assurance Quality Improvement) will make a prompt and thorough assessment, using investigative assessment process, to ascertain the facts of the case, including collecting information concerning the alleged consumer to have been abused or neglected. We will investigate the extent of the allegation, and the risk of overall harm to the consumer in order to determine whether the appropriate level has been set. When the report alleges serious neglect, the Owner (Licensee)/QP(QP/PD)/QA QI will immediately,</p>	V 512		

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V 512	<p>Continued From page 136</p> <p>but no later than 24 hours after receipt of the report, initiate the assessment.</p> <p>The reporting by Pinnacle Therapeutic to the Department of Health and Human Services (DHHS) of all allegations against staff as defined in G.S. (General Statute) 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the agency becoming aware of the allegation. The results of the agency's investigation shall be submitted to DHHS in accordance with G.S. 131E256(g). The MCO (Managed Care Organization) will be notified by the Owner (Licensee) in writing of any employee, intern, volunteer, or contractor who is under investigation for abuse and/or neglect. This will be done within 48 hours of learning of the investigation. If the Owner (Licensee) is under investigation for abuse and/or neglect, the QP(QP/PD)/QA QI will notify the MCO in writing within 48 hours of learning of the investigation. The agency shall update the MCO with any progress made in the investigation. Describe your plans to make sure the above happens.</p> <ul style="list-style-type: none"> -PTS (Pinnacle Therapeutic Services) will create an incident report log that will consist of Policy and Procedures for Incident reporting. -PTSS will retrain all staff members within the next 7 days on how to complete and report incident reports in a timely manner. -The Program Assistant will review all incident reports daily. -The Program Director (QP/PD) will follow up weekly to ensure incident reports are completed and submitted in a timely manner. -QA/QI review biweekly for the next 90 days to ensure all employees understand and can implement the expectation for completing all incident reports. -All staff will be retrained with incident 	V 512		

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NAME OF PROVIDER OR SUPPLIER PINNACLE THERAPEUTIC SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 2329 SPRINGS ROAD, NORTH EAST HICKORY, NC 28601
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V 512	<p>Continued From page 137</p> <p>reporting and will meet DHHS/IRIS standards."</p> <p>Client #3 was a 12-year-old female with diagnoses which included Oppositional Defiant Disorder-Moderate, Attention Deficit Hyperactivity Disorder, and Post Traumatic Stress Disorder and Disruptive Mood Dysregulation Disorder. Client #3 had a history of aggressive behaviors. There was no documentation of other details related to Client #3's history. On 4-10-23 Client #3 left the facility and was walking on a busy roadway after dark wearing dark colored clothing. The posted speed limit of the 5-lane roadway was 45 miles per hour. Client #3 was not dressed appropriately for the time or weather. She was wearing dark colored pajama pants, a black short sleeve shirt, open-toed slide sandals and no socks. The temperature in the local area dropped as low as 33 degrees Fahrenheit that evening. Client #3 was locked outside of the facility from 10:25 pm until sometime after 11:07 pm. Staff refused to allow Client #3 to enter the facility, despite LEO and Client #3 knocking on the facility doors and requesting entry. There was no indication of staff monitoring Client #3 while she was outside the facility. LEO left the facility and later returned at 11:41 pm and was informed by the QP/PD that Client #3 was back inside the facility. Additionally, Client #3 claimed she had been choked by the QP/PD. She stated that she no longer wanted to reside at the facility and she should have killed herself when she had the chance.</p> <p>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 within 23 days, an additional administrative penalty of \$500.00 per day will be imposed for each day the facility is out of</p>	V 512		

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V 512	Continued From page 138 compliance beyond the 23rd day.	V 512		
V 513	<p>27E .0101 Client Rights - Least Restrictive Alternative</p> <p>10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE</p> <p>(a) Each facility shall provide services/supports that promote a safe and respectful environment. These include:</p> <p>(1) using the least restrictive and most appropriate settings and methods;</p> <p>(2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others;</p> <p>(3) providing choices of activities meaningful to the clients served/supported; and</p> <p>(4) sharing of control over decisions with the client/legally responsible person and staff.</p> <p>(b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include:</p> <p>(1) using the intervention as a last resort; and</p> <p>(2) employing the intervention by people trained in its use.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to provide services and supports that promote a safe and respectful environment using the least restrictive and most appropriate settings and methods and failed to</p>	V 513		

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V 513	<p>Continued From page 139</p> <p>promote coping and engagement skills that are alternatives to injurious behaviors to self and others affecting 5 of 5 current clients (Clients #1-5) 4 of 4 Former Clients (FC #6-9). The findings are:</p> <p>Cross-Reference 10A NCAC 27G .0201 Governing Body Policies (V105). Based on record reviews and interviews, the facility failed to implement policies including admission assessments and discharge summaries.</p> <p>Cross-Reference 10A NCAC 27G .0202 Personnel Requirements (V107). Based on record reviews, observation and interviews, the facility failed to maintain a personnel file with required documentation affecting 1 of 1 Licensee, 11 of 11 current paraprofessional staff (Staff #'s 1-11) and 2 of 2 Former Staff (FS#12 and #13).</p> <p>Cross-Reference 10A NCAC 27G .0202 Personnel Requirements (V108). Based on record reviews, observation and interviews, the facility failed to maintain a personnel file with required documentation consisting of training programs of client rights/confidentiality, meeting the clients needs as specified in the treatment/habilitation plan, and infectious disease/blood borne pathogens affecting 1 of 1 Licensee, 11 of 11 current paraprofessional staff (Staff #'s 1-11) and 2 of 2 Former Staff (FS#12 and #13).</p> <p>Cross-Reference 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109). Based on record reviews and interviews, 1 of 1 Qualified Professional/Program Director (QP/PD) failed to demonstrate the knowledge, skills, and abilities required by the population served.</p>	V 513		

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V 513	<p>Continued From page 140</p> <p>Cross-Reference 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V111). Based on record reviews and interviews, the facility failed to ensure that assessments were completed prior to the delivery of services affecting 4 of 5 current clients (#1-#3 and #5) and 2 of 4 Former Clients (FC #8 and #9) and failed to document strategies to address the client's presenting needs affecting 5 of 5 current Clients (#1-#5) and 4 of 4 Former Clients (FC #6-#9).</p> <p>Cross-Reference 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112). Based on record reviews and interviews, the facility failed to develop and implement treatment strategies to address the needs of the clients affecting 4 of 5 current Clients (Clients #1-4) and 2 of 4 Former Clients (FC #6 and #7).</p> <p>Cross-Reference 10A NCAC 27G .0206 Client Records (V113). Based on record reviews and interviews, the facility failed to maintain client records affecting 5 of 5 current Clients (#1-#5) and 4 of 4 Former Clients (FC #6-#9).</p> <p>Cross-Reference 10A NCAC 27G .0209 Medication Requirements (V118). Based on observations, record reviews and interviews, the facility failed to ensure medications were administered to clients only on the written order of a Physician affecting 4 of 5 current clients (Client #1, #3-#5) and 1 of 4 Former Clients (FC #7) and failed to ensure medications were administered only by persons trained by a registered nurse, pharmacist or other legally qualified person for 2 of 2 Former Staff (FS #12 and #13), and failed to keep MARs current affecting 5 of 5 current clients</p>	V 513		

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V 513	<p>Continued From page 141</p> <p>(Clients #1-#5) and 1 of 4 Former Clients (FC) #7).</p> <p>Cross-Reference 10A NCAC 27G .0209 Medication Requirements (V123). Based on record reviews, observation and interviews, the facility failed to ensure medication errors were reported immediately to a physician or pharmacist affecting 2 of 5 current clients (Client #2 and #3) and 1 of 4 Former Clients (FC #7).</p> <p>Cross-Reference G.S. 131E-256 (d2) Health Care Personnel Registry (V131). Based on record reviews, observation and interviews, the facility failed to access the Health Care Personnel Registry (HCPR) prior to hiring health care personnel affecting 11 of 11 current staff (Staff #1-11) and 2 of 2 Former Staff (FS #12 and #13).</p> <p>Cross-Reference G.S. 131E-256 (g) Health Care Personnel Registry (V132). Based on record reviews and interviews, the facility failed to report and investigate all allegations of abuse against health care personnel and failed to protect clients from harm during the investigation process.</p> <p>Cross-Reference G.S. 122C-80 Criminal History record check required for certain applicants for employment (V133). Based on record review and interview, the facility failed to request a criminal history record check within 5 days of an offer of employment affecting the Licensee, 11 of 11 current staff (Staff #'s1-11) and 2 of 2 Former Staff (FS #12 and #13).</p> <p>Cross-Reference 10A NCAC 27G .0404 Operations during Licensed Period (V138). Based on record reviews and interviews, the facility failed to ensure that it would serve no more clients than the number for which it was licensed</p>	V 513		

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V 513	<p>Continued From page 142</p> <p>affecting 4 of 5 current Clients (#1-#4) and 3 of 4 Former Clients (FC #6-#8).</p> <p>Cross-Reference 10A NCAC 27G .0603 Incident Response Requirements for Category A and B Providers (V366). Based on record reviews and interviews, the facility failed to implement written policies governing their response to level I, II or III incidents.</p> <p>Cross-Reference 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers (V367). Based on record reviews and interviews, the facility failed to report all level II and III incidents to the Local Management Entity (LME)/Managed Care Organization (MCO) as required within 72 hours of becoming aware of the incident.</p> <p>Cross-Reference 10A NCAC 27D .0101 Policy on Rights Restrictions and Interventions (V500). Based on record reviews and interviews, the facility failed to ensure all instances of alleged abuse were reported to the local Department of Social Services (DSS) affecting 1 of 5 current Clients (Client #4) and 1 of 4 Former Clients (FC #6).</p> <p>Cross-Reference 10A NCAC 27G .0304 Facility Design And Equipment (V742). Based on observations and interviews, the facility failed to provide clients' privacy while bathing, dressing or using toilet facilities.</p> <p>Review on 4-13-23 of the initial Plan of Protection (POP) signed and dated by the Licensee on 4-13-23 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? The owner will engage with the current QP</p>	V 513		

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V 513	<p>Continued From page 143</p> <p>(Qualified Professional/Program Director (QP/PD) to discuss/review findings. The conversation will take place on 4/17/23. Describe your plans to make sure the above happens. The owner (Licensee) will work diligently with QP (QP/PD) to update clinical documentation to meet the states requirements. The owner (Licensee) will access if an outside consultant is required to obtain citation correction. All corrections will be addressed by 5/5/2023."</p> <p>Review on 4-13-23 of a second POP signed and dated by the Licensee on 4-13-23 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? The owner (Licensee) will engage with the current QP (QP/PD) to discuss/review findings. The conversation will take place on 4/17/23. Describe your plans to make sure the above happens. The owner (Licensee) will work diligently with QP (QP/PD) to update clinical documentation to meet the states requirements. The owner (Licensee) will access if an outside consultant is required to obtain citation correction. All corrections will be addressed by 5/12/23. 10A NCAC 27G .0201 Governing Body Policies/V105 - QP (QP/PD) will review policies and incorporate/implement in staff meetings. 10A NCAC 27G .0202 Personnel Requirements/V107 - The owner (Licensee) will appoint a new resource to become responsible QA/QI (Quality Assurance/Quality Improvement). The date of completion for all employees will be prior to employment. 10A NCAC 27G .0202 Personnel Requirements/V108 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals/V109 -</p>	V 513		

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V 513	<p>Continued From page 144</p> <p>The owner will review credentials and experience with QP (QP/PD). 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan/V111 - The QP (QP/PD) will create a checklist of all required documentation needed for intake and/or discharge. 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan/V112 - The QP (QP/PD) will create a checklist of all required documentation needed for intake and/or discharge. 10A NCAC 27G .0206 Client Records/V113 10A NCAC 27G .0208 Client Records/V115 10A NCAC 27G .0209 Medication Requirements/V118 - The owner (Licensee) will require all staff to retrain with our current training professional. 10A NCAC 27G .0209 Medication Requirements/V123 - The owner (Licensee) will require all staff to retrain with our current training professional. G.S. (General Statute) 131E-256 (d2) Health Care Personnel Registry/V131 - QA/QI will create a checklist which requires HCPR (Health Care Personnel Registry) check prior to employment. G.S. 131E-256 (g) Health Care Personnel Registry/V132 - QA/QI will create a checklist which requires HCPR checklist prior to employment. G.S. 122C-80 Criminal History record check required for certain applicants for employment/V133 - The QA/QI will create a checklist which requires HCPR checklist prior to employment. 10A NCAC 27G .0404 Operations during Licensed Period/V138 - Operations during licensed period will be review and discussed in staff meeting. 10A NCAC 27G .0603 Incident Response</p>	V 513		

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V 513	<p>Continued From page 145</p> <p>Requirements for Category A and B Providers/V366 - QA/QI will work with the QP to adhere to current process identified by DHHS (Department of Health and Human Services). 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers/V367 - QA/QI will work with the QP (QP/PD) to adhere to current process identified by DHHS. 10A NCAC 27D .0101 Policy on Rights Restrictions and Interventions/V500 - The owner (Licensee) will require each staff member to reengage with ADA (Adaptive Deescalation Alternatives) training professional. 10A NCAC 27G .0304 Facility Design And Equipment/V742 -The Owner (Licensee) & QA/Qi will be responsible for all facility design and equipment issues and address within a reasonable timeline."</p> <p>Review on 4-14-23 of a third POP received from the Licensee on 4-14-23 which was signed and dated by the Licensee on 4-13-23 revealed: "Rule Violation/Tag #/Citation Level: (Administrative Action and Crosses): 10A NCAC 27G .0201 Governing Body Policies/V105 -QP (QP/PD) will review policies and incorporate/implement them in staff meetings. -QP (QP/PD) will have weekly meetings with staff to review weekly progress in the home. -QP (QP/PD) will ensure all employees read policies and sign off before reporting to work. 10A NCAC 27G .0202 Personnel Requirements/V107 -QP (QP/PD) will ensure all personal training is completed before staff reports to work. -QP (QP/PD) will report to CEO (Chief Executive Officer/Licensee) once all staff paperwork is completed before starting work.</p>	V 513		

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V 513	<p>Continued From page 146</p> <p>-QP (QP/PD) will have weekly meetings to ensure that all employees are on the same page for program functions. 10A NCAC 27G .0202 Personnel Requirements/V108</p> <p>-QP (QP/PD) will ensure that all Personal files are completed before reporting to work.</p> <p>-QP (QP/PD) and staff will sign off on all training and review files 3 days prior to reporting to shift.</p> <p>-Not employer will be able to report to work unless all training and 3 days of on job training is completed. 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals/V109</p> <p>-The owner will review credentials and experience of QP (QP/PD) with input from the broad. 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan/V111 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan/V112</p> <p>-QP (QP/PD) will complete all assessments upon entering program with DSS (Department of Social Services) Social Worker to ensure plans are meeting individual needs during placement at Pinnacle Therapeutic services.</p> <p>-QP (QP/PD) and staff will attend 30-day PCP (Person Centered Plan) meetings to ensure all information is current to address youth needs.</p> <p>-QP (QP/PD) will provide in-house training for staff to understand goals and desire of youth plans. 10A NCAC 27G .0206 Client Records/V113</p> <p>-QP (QP/PD) needs to ensure that all files are completed within 24 hours of placement.</p> <p>-QP (QP/PD) needs to complete the intake checklist and training with youth within 72 hrs. (hours) of placement. 10A NCAC 27G .0208 Client Records/V115 10A NCAC 27G .0209 Medication Requirements/V118</p>	V 513		

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V 513	<p>Continued From page 147</p> <p>10A NCAC 27G .0209 Medication Requirements/V123</p> <p>-QP (QP/PD) will have all staff to retake medication training.</p> <p>-QP (QP/PD) will provided 3 days 1:1 training to ensure staff understand the expectations for passing medication at Pinnacle Therapeutic Services.</p> <p>-QP (QP/PD) will stop all staff from passing medication if they have two medication incidents within 6 months.</p> <p>-Staff must retake the class to pass medication if they have two errors within 6 months.</p> <p>G.S. 131E-256 (d2) Health Care Personnel Registry/V131</p> <p>G.S. 131E-256 (g) Health Care Personnel Registry/V132</p> <p>G.S. 122C-80 Criminal History record check required for certain applicants for employment/V133</p> <p>-All employees Healthcare personnel registered and criminal history must be completed before staff reports to work.</p> <p>10A NCAC 27G .0404 Operations during Licensed Period/V138</p> <p>10A NCAC 27G .0603 Incident Response Requirements for Category A and B Providers/V366</p> <p>10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers/V367</p> <p>-QP (QP/PD) will have all staff to review the incidents policy.</p> <p>-QP (QP/PD) will check daily to ensure incident reports are completed as needed.</p> <p>-Qp (QP/PD) will review and implement Pinnacle incident policy and procedures as of 4/14/23.</p> <p>10A NCAC 27D .0101 Policy on Rights Restrictions and Interventions/V500</p> <p>10A NCAC 27G .0304 Facility Design And</p>	V 513		

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NAME OF PROVIDER OR SUPPLIER PINNACLE THERAPEUTIC SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 2329 SPRINGS ROAD, NORTH EAST HICKORY, NC 28601
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 513	<p>Continued From page 148</p> <p>Equipment/V742 - QP (QP/PD) will ensure that damaged property will be corrected or addressed within 72 hrs. of the incidents." "What immediate action will the facility take to ensure the safety of the consumers in your care? The owner (Licensee) will engage with current QP (QP/PD) to discuss/review findings. The conversation will take place 4/17/23. Describe your plans to make sure the above happens. The owner (Licensee) will work diligently with the QP (QP/PD) to update the clinical documentation to meet the states requirements. The owner (Licensee) will access if an outside consultant is required to obtain citation correction. All corrections will be addressed by 5/12/23. 10A NCAC 27G .0201 Governing Body Policies/V105 - QP (QP/PD) will review policies and incorporate/implement in staff meetings. 10A NCAC 27G .0202 Personnel Requirements/V107 - The owner (Licensee) will appoint a new resource to become responsible QA/QI. The date of completion for all employees will be prior to employment. 10A NCAC 27G .0202 Personnel Requirements/V108 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals/V109 - The owner (Licensee) will review credentials and experience with QP (QP/PD). 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan/V111 - The QP (QP/PD) will create a checklist of all required documentation needed for intake and/or discharge. 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan/V112 - The QP (QP/PD) will create a checklist of all required documentation needed for intake and/or</p>	V 513		

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V 513	<p>Continued From page 149</p> <p>discharge.</p> <p>10A NCAC 27G .0206 Client Records/V113</p> <p>10A NCAC 27G .0208 Client Services/V115</p> <p>10A NCAC 27G .0209 Medication Requirements/V118 - The owner (Licensee) will require all staff to retain with our current training professional.</p> <p>10A NCAC 27G .0209 Medication Requirements/V123 - The owner (Licensee) will require all staff to retain with our current training professional.</p> <p>G.S. 131E-256 (d2) Health Care Personnel Registry/V131 - QA/QI will create a checklist which requires HCPR check prior to employment.</p> <p>G.S. 131E-256 (g) Health Care Personnel Registry/V132 - QA/QI will checklist which requires a HCPR checklist prior to employment.</p> <p>G.S. 122C-80 Criminal History record check required for certain applicants for employment/V133 - The QA/QI will checklist which requires a HCPR checklist prior to employment.</p> <p>10A NCAC 27G .0404 Operations during Licensed Period/V138 - Operations during licensed period will be review and discussed in staff meetings.</p> <p>10A NCAC 27G .0603 Incident Response Requirements for Category A and B Providers/V366 - QA/QI will work with the QP to adhere to current process identified by DHHS (Department of Health and Human Services).</p> <p>10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers/V367 - QA/QI will work with the QP to adhere to current process identified by DHHS.</p> <p>10A NCAC 27D .0101 Policy on Rights Restrictions and Interventions/V500 - The owner (Licensee) will require each staff member to reengage with ADA (Adaptive Deescalation Alternatives) training professional.</p>	V 513		

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V 513	<p>Continued From page 150</p> <p>10A NCAC 27G .0304 Facility Design And Equipment/V742 -The Owner (Licensee) & QA/QI will be responsible for all facility design and equipment issues and address within a reasonable timeline."</p> <p>Clients served by the facility ranged in age from 12 to 16 years old. They had diagnoses including, but not limited to, Attention Deficit Hyperactivity Disorder, Disruptive Mood Dysregulation Disorder, Post Traumatic Stress Disorder, Conduct Disorder, Unspecified Personality Disorder, Bipolar Disorder, Oppositional Defiant Disorder, Cluster B Personality Traits, Adjustment Disorder, and Anxiety. Diagnoses were not documented in the records for Client #4, Former Client (FC) #6, and FC #9. Clients had histories of behaviors including, but not limited to, self-harm, physical aggression, verbal aggression, elopement, physical abuse, and sexual abuse. The facility did not implement their admission and screening policy resulting in clients not being assessed for the level of care required based upon their clinical histories and level of need. Treatment strategies were not developed and implemented to address clients' needs. Law enforcement was called to the facility at least 24 times between 2-24-23 and 4-18-23 for incidents of elopements, aggressive behaviors, assault, property damage, and larceny of a motor vehicle. Client records were not maintained as required resulting in missing client identification sheets, diagnoses, admission screenings and assessments, treatment plans, documentation of services provided and progress toward outcomes. No discharge summaries were completed on discharged clients. Staff were not trained in required topics including, but not limited to, client rights, confidentiality, and client specific needs. The facility did not accurately document</p>	V 513		

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V 513	<p>Continued From page 151</p> <p>medication administration records and maintain records or physician orders. Medications were administered by staff who were not certified in medication administration. Medication errors and refusals were not documented on incident reports and there were no follow up consultations with a pharmacist or physician. Due to the lack of documentation, the amount of medication errors the degree of impact to the health and safety of the clients could not be determined. Incident reporting was not completed to document all incident reports. Required notifications after incidents to the Department of Social Services and Health Care Personnel Registry (HCPR) were not completed. Allegations of abuse were not reported, investigated, and actions were not implemented to protect the clients during the investigation process. Numerous incidents were not reported through the North Carolina Incident Response Improvement System. The facility operated beyond its licensed capacity for 10 days from 3-2-23 to 3-11-23. Staff records did not include dates of hire, job titles, job descriptions, and education credentials making it impossible to determine if required vetting occurred prior to offers of employment. Staff records were missing HCPR and criminal background checks. Clients were not afforded privacy as evidenced by a missing window covering in the shower stall of the upstairs shower. The Qualified Professional/Program Director was responsible for the oversight of the facility but did not identify and rectify the deficient practices within the facility to improve client services and safety. The Licensee identified that he was not a staff member with accountability for the clients but was present for the business operations of the facility. The facility has been licensed since 2-3-23 and serving clients since 2-9-23. This deficiency constitutes a Type A1 rule</p>	V 513		

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V 513	Continued From page 152 violation for serious neglect and must be corrected within 23 days. An administrative penalty of \$5,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of \$500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 513		
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 manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility was not maintained in a safe, clean, attractive, and orderly manner. The findings are: Review on 4-12-23 of Client #1's record revealed: -Age: 16 years old. -Date of admission 2-24-23. -Diagnoses: Attention Deficit Hyperactivity Disorder, Disruptive Mood Dysregulation, Post Traumatic Stress Disorder, Conduct Disorder and Unspecified Personality Disorder. -History of self-harming and physically aggressive behavior. Review on 4-12-23 of Client #3's record revealed:	V 736		

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V 736	<p>Continued From page 153</p> <p>-Age: 12 years old. -Date of Admission 3-1-23. -Diagnosis: per application dated 3-1-23 completed by guardian indicated Oppositional Defiant Disorder Moderate, Attention Deficit Hyperactivity Disorder, Post Traumatic Stress Disorder. -Progress notes showed Client #3 had a history of verbal aggression and threatened to stab a staff.</p> <p>Review on 4-12-23 of Client 4's record revealed: -Age: 14 years old. -Date of admission 2-23-23. -Diagnosis was not documented in Client #4's record. -Progress notes dated 4-2-23 showed Client #4 threatened to harm herself with glass from the broken glass pane on 4-1-23.</p> <p>Observation on 4-11-23 of the facility at 2:00 pm revealed: -The back door to the facility had 9 glass panes (3 rows of glass with 3 panes each), the left glass pane on the second row had a large hole with shards of glass. -The shared bedroom of Client #1 and #4 was full of scattered clothing and 2 clothes hampers overflowing with clothes, trashcan was overflowing with empty food containers (potato chip bags and empty water bottles), the side table had food, empty drink bottles, there was empty cereal boxes and candy wrappers beside client #1's bed, shoes, electronics and cords were scattered in disarray on the floor, and a red dried substance on the floor. -Client #2's bedroom was full of scattered clothing on the floor, a turned over clothes hamper with clothes spilling out on the floor, the vacant unmade bed was covered in scattered clothes,</p>	V 736		

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V 736	<p>Continued From page 154</p> <p>plastic grocery bags, a football, a comforter and sheets in a pile in the corner of the bed, a dresser covered with empty juice and soda bottles, empty cups, various items scattered on the floor around the room (empty candy boxes and empty drink bottles, shoes, electrical cords, plastic, and clothing).</p> <p>-The shared bedroom of Client #3 and Client #5 was full of scattered clothing and the dresser was covered in trash (empty food wrappers and empty water bottles) and scattered clothing. Two side tables had dirty dishes with dried food particles. Articles of clothing were scattered on the floor, an office chair was full of clothing, a brown dried substance smeared on the wall and a red dried substance on the floor.</p> <p>-The vacant bedroom had at least 8 large black trash bags overflowing with clothing piled on the floor.</p> <p>-The sink in the upstairs bathroom had a white thick pasty substance covering the majority of the sink basin.</p> <p>-The downstairs bathroom toilet seat was cracked.</p> <p>-The downstairs bathroom wall mounted sink was separated from the wall.</p> <p>Observation on 4-12-23 of the facility at 10:47 am revealed:</p> <p>-The back door still had broken shards of glass in the windowpane as previously observed on 4-11-23.</p> <p>-All of the bedrooms were in the same condition as previously observed on 4-11-23.</p> <p>-Both upstairs and downstairs bathrooms were in the same condition as previously observed on 4-11-23.</p> <p>Observation on 4-13-23 of the facility at 9:00 am revealed:</p>	V 736		

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V 736	<p>Continued From page 155</p> <p>-The back door still had broken shards of glass in the windowpane as previously observed on 4-11-23.</p> <p>-All of the bedrooms were in the same condition as previously observed on 4-11-23.</p> <p>-Both upstairs and downstairs bathrooms were in the same condition as previously observed on 4-11-23.</p> <p>Observation on 4-14-23 of the facility at 3:45 pm revealed:</p> <p>-All of the bedrooms were in the same condition as previously observed on 4-11-23.</p> <p>-Additional observation on 4-14-23 of the shared bedroom of Client #3 and Client #5 of a glass cylinder shaped candle on a side table that was broken with sharp, jagged edged pieces of glass sticking out, and a lamp that was turned on and had a dark blue colored cloth completely covering the top of the lamp shade.</p> <p>Review on 4-13-23 of a form titled "Pinnacle Therapeutic Services Safety and Welfare Checks" revealed:</p> <p>-"Routine daily inspections are conducted by persons employed by Pinnacle Therapeutic Services, Inc. to ensure the overall safety, sanitation and well-being of our residents is met by conducting room inspections for cleanliness and sanitation purposes. Areas to be reviewed include: Beds being made (mattress cover, sheets, pillowcase, pillow), organization of items in the room (dresser, nightstand, desk), dirty clothes in hamper ... floor clean (check under beds), clean clothes put away properly ..."</p> <p>-"Concern for the cleanliness, sanitary and safe environment in which the child/ youth in residing or have disorders that may lead to self-harm, self-mutilation or other depressive symptom: thumbtacks, straight pins, safety pins, staples,</p>	V 736		

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V 736	<p>Continued From page 156</p> <p>sharp objects that could be used for cutting and self- injurious action, scissors (broken glass-mirror, etc.) ..."</p> <p>Review on 4-13-23 of facility incident reports revealed: -On 4-2-23 Client #4 tried to harm peers and staff. Client #4 removed glass from the door and was threatening to physically harm her peers and staff with the glass.</p> <p>Review on 4-18-23 of local police department body camera video footage dated 4-10-23 revealed: -On 4-10-23 at 11:00 pm Client #3 touched the backdoor with the broken windowpane with jagged glass. -On 4-10-23 at 11:04 pm Client #3 made statements of self-harm and suicidal ideation.</p> <p>Review on 4-12-23 of the local police department computer-aided dispatch report dated 4-12-23 revealed: -On 4-2-23 at 5:59 pm Client #4 " ...threatening to kill herself, has ...piece of glass in hand threatening to cut herself ..."</p> <p>Interview on 4-11-23 with Client #3 revealed: -She broke the glass pane of the back door while playing ball " ...that was about a week ago."</p> <p>Interview on 4-11-23 with Client #4 revealed: -Acknowledged taking the glass from the backdoor and threatening Staff #1.</p> <p>Interview on 4-13-23 with Staff #1 revealed: -Aware the glass pane on the back door was broken and the broken glass remained in the windowpane. -Client #3 broke the glass pane on the back door</p>	V 736		

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V 736	<p>Continued From page 157</p> <p>with her hand while playing " ...happened on 4-1-23 or 4-2-23." -Clients were responsible for cleaning their rooms daily.</p> <p>Interview on 4-13-23 with Staff #5 revealed: -Aware the glass pane on the back door was broken and the remaining glass in the pane was in shards. -Client #4 and Staff #1 broke the glass pane on the back door during an altercation. -Clients are responsible for cleaning their rooms, " ...Sometimes I will go in behind them ..."</p> <p>Interview on 4-17-23 with the Qualified Professional/Program Director revealed: -Aware the glass pane on the back door was broken and the remaining glass in the pane was in shards. -Client #4 broke the glass pane on the back door. " ...It was when [Client #4] got a piece of glass and got committed so it was last week within the past 7 days."</p> <p>Interview on 4-11-23 with the Licensee revealed: -"We are new (newly licensed facility) ...the level of care, we didn't get the right mix. We have worked diligently to address any issues. They (Clients) have specific issues ...We want to make sure we can address it and handle it, suicidal concerns ...She (Client #4) wants to hurt herself and cut herself."</p> <p>Review on 4-13-23 of the Plan on Protection (POP) signed and dated by Licensee on 4-13-23 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? The owner (Licensee) will work with the current handyman contractor to ensure that all identified</p>	V 736		

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V 736	<p>Continued From page 158</p> <p>safety concerns are addressed. The owner (Licensee) will purchase replacement glass for the back door. The owner (Licensee) will hire a cleaning service to do the initial cleaning and will require daily cleaning from clients. The identified issue will be addressed by 4/15/23. Describe your plans to make sure the above happens. The owner (Licensee) will reach out to the household handy man contractor to describe safety concern and have addressed by 4/15/23. Will call cleaning service and set appointment by 4/20/2023."</p> <p>Review on 4-14-23 of the amended POP signed and dated by Licensee on 4-13-23 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? The owner (Licensee) will work with the current handyman contractor to ensure that all identified safety concerns are addressed. The owner (Licensee) will purchase replacement glass for the back door. The owner (Licensee) will hire a cleaning service to do the initial cleaning and will require daily cleaning from clients. The immediate plan are as follows:</p> <ol style="list-style-type: none"> 1) Broken window - We have cleaned up the remaining pieces of broken glass and will replace with cardboard temporarily until handyman can replace with glass. This will ensure that no potential glass fragments remain. 2) We have replaced the toilet seat in the downstairs bathroom. 3) We have placed a makeshift curtain drape over the upstairs bathroom window. <p>The remaining identified issue will be addressed by 4/15/23 with the handyman. Describe your plans to make sure the above happens.</p>	V 736		

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V 736	<p>Continued From page 159</p> <p>The owner (Licensee) will reach out to the household handy man contractor to describe safety concern and have addressed by 4/15/23. Will call cleaning service and set appointment by 4/20/2023."</p> <p>Clients served by the facility ranged in age from 12 to 16 years old. They had diagnoses including, but not limited to, Attention Deficit Hyperactivity Disorder, Disruptive Mood Dysregulation Disorder, Post Traumatic Stress Disorder, Conduct Disorder, Unspecified Personality Disorder, and Oppositional Defiant Disorder Moderate. Clients' behaviors included self-harm, physically aggressive and threatening behaviors towards others. An incident report dated 4-2-23 showed a client threatening to harm herself, staff, and her peers with a piece of glass from the back door which indicated the glass had been broken on 4-1-23. On 4-10-23 Client #3 was seen on local police body camera footage touching the broken glass on the back door and having threatening behaviors. During observations of the facility between 4-11-23 and 4-14-23, the back door had a broken glass pane with shards of glass exposed. Staff were aware of the broken glass as of 4-1-23 and did not make attempts to remove broken shards of glass until 4-14-23 in response to a requested Plan of Protection. Clients had access to the area of broken glass for 13 consecutive days. This posed a safety risk to the clients due to the aggressive, threatening, and self-injurious behaviors.</p> <p>This deficiency constitutes a Type A2 rule violation for substantial risk of serious harm and must be corrected within 23 days. An administrative penalty of \$500.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of \$500.00 day will be imposed for each day the facility is out of</p>	V 736		

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NAME OF PROVIDER OR SUPPLIER PINNACLE THERAPEUTIC SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 2329 SPRINGS ROAD, NORTH EAST HICKORY, NC 28601
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 736	Continued From page 160 compliance beyond the 23rd day.	V 736		
V 742	<p>27G .0304(a) Privacy</p> <p>10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT</p> <p>(a) Privacy: Facilities shall be designed and constructed in a manner that will provide clients privacy while bathing, dressing or using toilet facilities.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide clients' privacy while bathing, dressing or using toilet facilities. The findings are:</p> <p>Observations on 4-11-23 at 2:00 pm, 4-12-23 at 9:51 am, 4-13-23 at 9:45 am of the facility upstairs bathroom revealed: -An exterior window was on the upper wall in the shower stall and had no covering for privacy. -The window looked out over the side of the facility property facing the driveway and parking lot as well as neighboring houses.</p> <p>Interview on 4-11-23 with the Licensee revealed: -Was not aware that a privacy covering was needed for that window on the second floor.</p> <p>This deficiency is cross referenced into 10A NCAC 27E .0101 Least Restrictive Alternative (V513) for a Type A1 rule violation and must be corrected within 23 days.</p>	V 742		