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V 000	INITIAL COMMENTS An annual, complaint, and follow up survey was completed on June 2, 2023. The complaint was substantiated (intake #NC00201738). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 4 and currently has a census of 4. The survey sample consisted of an audit of 2 current clients and 1 discharged client.	V 000		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to have a fire and disaster drills held at least quarterly and repeated on each shift. The	V 114		

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V 114	Continued From page 1 findings are: Interview on 6/1/23 Staff #3 stated: -There were 3 shifts as follows: -1st shift: 8am-4pm -2nd shift: 4pm-12am -3rd shift: 12am-8am Review on 6/1/23 and 6/2/23 of the facility fire and disaster records from 4/1/22-3/31/23 revealed: -Quarter 4/1/22-6/30/22: -1st shift: Drills were documented on 4/7/22 at 8:01am and 5/30/22 at 3:01pm. Only one drill time was documented for each day, but both fire and disaster drills were marked on the report. -2nd shift: Drill documented on 6/7/22 at 5:32pm. Only one drill time was documented, but both fire and disaster drills were marked on the report. -3rd shift: No fire or disaster drills documented. -Quarter 7/1/22-9/30/22: -1st shift: Drills documented on 7/13/22 at 8:08am, 8/15/22 at 3:06 pm, and 9/15/22 at 10:08am. Only one drill time was documented for each day, but both fire and disaster drills were marked on the report. -2nd shift: Drill documented on 8/25/22 at 6:25pm. Only one drill time was documented, but both fire and disaster drills were marked on the report. -3rd shift: No disaster drill documented. -Quarter 10/1/22-12/31/22: -1st shift: No fire or disaster drills documented. -2nd shift: No disaster drill documented. -3rd shift: No disaster drill documented. -Quarter 1/1/23-3/31/23: -2nd shift: No disaster drill documented.	V 114		

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V 114	Continued From page 2 -3rd shift: No disaster drill documented. Interview on 6/1/23 client #3 stated: -He had been a resident in the facility for 6 or 7 months. -He had practiced fire and tornado drills. -When a fire drill was done, they never did a tornado drill immediately before or after the fire drill. Interview on 6/1/23 client #1 stated: -He had been a resident in the facility for 8 months. -When fire drills were done the staff would say "fire drill" and everyone would go outside to the back yard near a pole. -No other drills were ever done when fire drills were done. -Other than fire drills, he was not aware of any other kind of drills. -He had not participated in any tornado drills at the facility. Interview on 6/2/23 the Owner/Licensed Professional stated: -Drills were done monthly. -The drills provided to the surveyor were all of the drills that had been documented for the 12 months reviewed. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 114		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall	V 118		

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V 118	Continued From page 3 only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (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. (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: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to administer medications as ordered by the physician, and maintain a current/accurate MAR with medications recorded immediately after administration, affecting 2 of 2 audited current clients (#1, #3) and 1 of 1 former	V 118		

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V 118	Continued From page 4 client (FC#5). The findings are: Finding #1: Review on 6/1/23 of client #1's record revealed: -17 year old male admitted 9/16/22. -Diagnoses included conduct disorder, childhood onset; adjustment disorder with mixed anxiety and depressed mood. -Hospital visit summary dated 4/26/23 for non-displaced fracture of the left wrist. Medications listed included Hydrocodone-acetaminophen 5-325mg (milligrams), 1 tablet every 6 hours PRN (as needed) for moderate pain. Review on 6/1/23 of client #1's medication orders/dates revealed: -5/25/23: Melatonin 10 mg at bedtime. (sleep aid) -5/25/23: Zyrtec 10 mg 1 daily PRN. (allergy symptom relief) -5/25/23: Flonase 50 mcg (micrograms), 1 spray in each nostril BID (twice daily) PRN. (allergy symptom relief) -No order for Ibuprofen 200 mg. (pain) -No order for Tylenol 650 mg. (pain) -No signed order for Hydrocodone-acetaminophen 5-325mg. -Form, "OTC (over the counter) Medication Order" dated 2/7/23 and signed by the Family Nurse Practitioner, listed 13 "symptoms/complaints" to include "headaches." No other pain symptoms listed. No medications or medication orders had been documented on the form. Review on 6/1/23 and 6/2/23 of client #1's MARs from 3/1/23 - 6/1/23 revealed: -Documentation of Melatonin 10 mg on 5/28/23, 5/30/23, and 5/31/23 was blank. -Zyrtec 10 mg was scheduled on the May MAR	V 118		

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V 118	Continued From page 5	V 118		

for 8 pm.
-Zyrtec 10 mg was documented on 3/28/23-3/30/23 without the time administered documented.
-Flonase 50 mcg documented on 5/30/23. The MAR listed a daily scheduled time of 8 pm.
-Hydrocodone 325 mg was scheduled on the April MAR to be given at 12am and 6pm. The medication was documented at the scheduled times for 4/18/23-4/20/23.
-Motrin 200 mg, 3 tablets, was documented on 4/6/23 at 6am, 4:30pm, and 11 pm; 4/7/23 at 10:30am; and, 4/25/23 at 8pm.
-Motrin 200 mg was documented on 5/1/23 at 8pm, and 5/17/23 at 12pm.
-Tylenol 325mg, 2 tablets, was documented 4/5/23 (no time); 4/6/23 at 7:30pm; and, 4/7/23 at 6:30am and 1pm.

Observation on 6/2/23 at 12:20pm revealed an empty medication bottle labeled Hydrocodone-acetaminophen 5-325mg, 1 tablet every 6 hours PRN for moderate pain; dispensed 28 tablets on 4/11/23.

Finding #2:
Review on 6/1/23 and 6/2/23 of client #3's record revealed:
-16 year old male admitted 11/7/22.
-Diagnoses included major depressive disorder, recurrent episode; and cannabis use, unspecified.
-Order dated 1/11/23 for Trazodone 100 mg at bedtime. (Depression)
-Order dated 1/6/23 for Ibuprofen 600 mg every 8 hours PRN.

Review on 6/1/23 and 6/2/23 of client #3's MARs from 3/1/23 - 6/1/23 revealed:
-Documentation of Trazodone 100 mg at bedtime on 5/2/23, 5/30/23, and 5/31/23 was blank.

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V 118	Continued From page 6	V 118		

-Ibuprofen 400 mg PRN had been transcribed to March, April, May, and June 2023 MARs. No frequency was transcribed.
-Ibuprofen 400mg was documented on 3/6/23, 3/24/23, 4/3/23, 4/5/23-4/7/23, 4/10/23, 4/11/23, 4/15/23, 4/16/23, 4/18/23-4/21/23, 4/24/23-4/28/23, 4/30/23, 5/1/23, 5/6/23-5/9/23, 5/14/23, 5/16/23, 5/18/23, 5/20/23, 5/23/23, 5/27/23. No documentation of the time the medication had been administered.

Observation on 6/2/23 at 12:25pm of client #3's Ibuprofen medication on hand revealed the strength was 600 mg and the frequency was every 8 hours PRN.

Finding #3:
Review on 6/1/23 of FC#5's record revealed:
-14 year old male admitted 10/25/22 and discharged 4/20/23.
-Diagnoses included conduct disorder, childhood onset with limited pro-social emotions, severe; and attention deficit hyperactive disorder, combined presentation, moderate.
-Order dated 12/7/22 for Trazodone 100mg as needed at bedtime.
-No order for Epi Pen. (severe allergic reactions)

Review on 6/1/23 and 6/2/23 of FC#5's MARs for March and April 2023 revealed:
-Trazodone 100 mg was transcribed to the March and April 2023 MARs to be administered daily at 8pm. The Trazodone had been documented daily from 3/1/23-4/19/23.
-"Epi Pen ... 1 syringe ... PRN per reaction" had been transcribed to the March and Aril MARs. There was no documentation the medication had been administered.

Interview on 6/1/23 and 6/2/23 the

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V 118	Continued From page 7 Owner/Licensed Professional stated: -The Qualified Professional reviewed MARs each Monday and would have staff sign off any blanks. -There was no other documentation to differentiate between a late entry for medication administration and when a medication was recorded immediately after administration. -She should have signed client #1's MAR for Melatonin 10 mg on 5/28/23, 5/30/23, and 5/31/23. -She was not aware times for PRN medications had to be documented and should not be scheduled unless ordered at a scheduled time PRN. -Client #1 had broken his arm in April while on a home visit. His family had taken him to the hospital when he first broke his arm. -Client #1 was home for 6 days after he broke his arm. The family did not provide an order for his Hydrocodone-acetaminophen 5-325mg. The facility continued his pain medication given to the facility by the family until it was completed. -Client #1's hospital visit summary dated 4/26/23 was a follow up visit for his broken arm. -She thought the signed form, "OTC (over the counter) Medication Order," could be used as an order for any OTC medication administered for a listed symptom. She did not understand complete orders were required for OTC medications. -The transcription of Ibuprofen dosage on client #3's MAR was a documentation error; his medication on hand and administered was 600 mg. -She had started a June 2023 form to document the times when PRN medications were administered. -The facility never had an order for FC#5's Epi Pen. The medication was on hand during his admission but never administered.	V 118		

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V 118	Continued From page 8 -She did not recall if FC#5's Epi Pen was labeled; the pharmacist could not find an order for the medication. This deficiency constitutes a recited deficiency and must be corrected within 30 days.	V 118		
V 300	27G .1708 Residential Tx. Child/Adol - Trans or dischg 10A NCAC 27G .1708 TRANSFER OR DISCHARGE (a) The purpose of this Rule is to address the transfer or discharge of a child or adolescent from the facility. (b) A child or adolescent shall not be discharged or transferred from a facility, except in case of emergency, without the advance written notification of the treatment team, including the legally responsible person. For purposes of this Rule, treatment team means the same as the existing child and family team or other involved persons as set forth in Paragraph (c) of this Rule. (c) The facility shall meet with existing child and family teams or other involved persons including the parent(s) or legal guardian, area authority or county program representative(s) and other representatives involved in the care and treatment of the child or adolescent, including local Department of Social Services, Local Education Agency and criminal justice agency, to make service planning decisions prior to the transfer or discharge of the child or adolescent from the facility. (d) In case of an emergency, the facility shall notify the treatment team including the legally responsible person of the transfer or discharge of the child or adolescent as soon as the emergency situation is stabilized.	V 300		

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V 300	Continued From page 9 (e) In case of an emergency, notification may be by telephone. A service planning meeting as set forth in Paragraph (c) of this Rule shall be held within five business days of an emergency transfer or discharge. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure a service planning meeting was held within five business days of an emergency discharge affecting 1 of 1 former clients (FC#5). The findings are: Review on 6/1/23 of FC#5's record revealed: -14 year old male admitted 10/25/22 and discharged 4/20/23. -Diagnoses included conduct disorder, childhood onset with limited pro-social emotions, severe; and attention deficit hyperactive disorder, combined presentation, moderate. -History of suicidal and homicidal ideations. -History of multiple criminal charges involving guns, communicating treats, and violence. -3/2/23 Treatment Plan progress note on "Action Plan" documented, "[FC#5] has made a successful transition to the Level 3 group home. He is building therapeutic bonds with staff and receptive to therapy and other interventions. He is able to verbalize reasons he is in care and what led to his admission to the facility. ... He has had numerous verbal altercations with staff but has been able to use coping skills to stop and think about consequences to prevent physical aggression. He gets along well with his peers but prefers to spend more time alone..." -4/18/23 progress note signed by the	V 300		

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Owner/Licensed Professional (LP), documented FC#5's violent behavior toward a peer was discussed noting it could be grounds for "expulsion" and would not be tolerated; the safety of the other clients was a priority; and, the seriousness of making treats and assaulting his peer was discussed.
-No documentation of a service planning meeting within 5 days of his discharge on 4/20/23.

Review on 6/2/23 of FC#5's Comprehensive Clinical Assessment dated 4/19/23 revealed:
-Mental Status Exam: "Client is in elevated emotional state. Affect is hostile. ... He states he is not depressed and exhibits homicidal ideation toward a peer in particular and toward staff. He states, 'I'll kick your mother- f-----g a-- right here mother f-----r! Y'all can't guard me! I'll kill h--l out of him.' Such statements were made to three male staff who are much bigger in stature and to a peer who is smaller. These threats were made repeatedly at least five times. He yelled, 'Go ahead and lock me up, I been locked up before. I can't stay here. I'm gonna kill somebody!' He is not de-escalating. He is not having visual or auditory hallucinations."
-Level of Care Recommendations: "It is determined by this clinician that client is in regression and poses a serious physical threat to others in the current facility, as well as to himself (stating he no longer cares what happens to him.) His symptoms can no longer be managed in current placement. Recommendation is a PRTF (Psychiatric Residential Treatment for Children and Adolescents) for safety of himself and others."

Interview on 6/2/23 the Owner/LP stated:
-She had observed a gradual regression in FC#5 following his court date in December 2022 when

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V 300	Continued From page 11 some of his more serious legal charges had been dropped. FC#5 had "less reason to comply." -FC#5's friendship with client #3 fluctuated between being good a then one of conflict. -FC#5 perceived client #3 "disrespected" FC#5's "gang" in February 2023 and he was not able to "let it go." -On 4/19/23 FC#5 became physically violent and his threats progressed to be specific homicidal threats. -She decided to use the option of a mental health involuntary commitment (IVC) rather than calling the police for an arrest. -She initiated an IVC by going to the magistrate's office around 2pm on 4/19/23. -By the time the sheriff's officer came to transport FC#5 to the Emergency Room (ER) it was after 12am, therefore, his ER admission was on 4/20/23. -Given his behaviors it was her decision that having staff transport him directly to the ER on 4/19/23 was not safe. -FC#5 was released from the hospital and returned to the facility around 4pm on 4/20/23. -Prior to 4/19/23 staff had been able to verbally "diffuse" FC#5's aggression, but on the 4/19/23 he was more aggressive and "talking did not do any good." -She proceeded with an emergency discharge after he returned to the facility from the ER on 4/20/23. -She had phone conversations with FC#5's Department of Social Services Guardian Representative and his Care Manager on 4/20/23 about his emergency discharge. -She held a "debrief" with the staff following FC#5's discharge. -She had not held a formal service planning meeting within 5 days of his emergency discharge on 4/20/23.	V 300		

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V 300	Continued From page 12 -She checked her discharge policy and it did not include the need for a service planning meeting within 5 days of an emergency discharge.	V 300		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing	V 366		

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V 366	Continued From page 13	V 366		

their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by:
(1) immediately securing the client record by:
(A) obtaining the client record;
(B) making a photocopy;
(C) certifying the copy's completeness; and
(D) transferring the copy to an internal review team;
(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:
(A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;
(B) gather other information needed;
(C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and
(D) issue a final written report signed by the owner within three months of the incident. The 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

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V 366	Continued From page 14 include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to report incidents as required by the rule. The findings are: Refer to V367 for: -Client #2 was placed in a restrictive intervention following a physical altercation with former client #5. -There was no incident report created in response to the use of a restrictive intervention.	V 366		

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V 366	Continued From page 15 Interview on 6/2/23 the Owner/Licensed Professional stated:. -She was unaware of any restrictive interventions used in the last 6 months. -The clients were always able to be redirected verbally. -Moving forward, she would ensure all necessary documentation was completed following a restrictive intervention.	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.	V 367		

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V 367	Continued From page 16 (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident;	V 367		

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V 367	Continued From page 17 (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure critical incident reports were submitted to the Local Management Entity (LME) within 72 hours as required. The findings are: Review on 6/1/23 of the North Carolina Incident Response Improvement System from 1/1/23 - 6/1/23 revealed: - There were no documented level II incident reports for restrictive interventions being implemented. Review on 6/1/23 and 6/2/23 of client #3's record revealed: -16 year old male admitted 11/7/22. -Diagnoses included major depressive disorder, recurrent episode; and cannabis use, unspecified.	V 367		

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V 367	Continued From page 18 Interview on 6/1/23 client #3 stated: -He had lived at the facility for approximately 6 - 7 months. -He had been placed in a restrictive intervention by the Qualified Professional (QP) but could not recall the date. -The restrictive intervention followed an argument with former client (FC) #5. -The Qualified Professional (QP) came from behind him and wrapped his arms around him during the intervention. Interview on 6/2/23 the QP stated: -He had been employed with the facility for approximately 1 - 1.5 years. -There was an incident in late March/early April 2023 in which client #3 and FC #5 got into a physical altercation requiring them to be separated. -FC #5 hit client #3 before they could be separated. -He "covered [client #3] so that he wouldn't get hit again." -He "held him and walked him to his room so he could calm down." -There had been no additional incidents requiring holds of any kind. Interview on 6/1/23 client #2 stated: -He had lived at the facility for a few months. -He had witnessed restrictive interventions being implemented on client #3 and former client #5 following a physical altercation on an unknown date. -Following the altercation, the QP "grabbed" client #3 and staff #1 "grabbed" FC #5. -There had been no other restrictive interventions witnessed.	V 367		

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V 367	Continued From page 19 Interview on 6/2/23 the Owner/Licensed Professional stated:. -She was unaware of any restrictive interventions used in the last 6 months. -The clients were always able to be redirected verbally. -Moving forward, she would ensure all necessary documentation was completed following a restrictive intervention.	V 367		
V 521	27E .0104(e9) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (9) Whenever a restrictive intervention is utilized, documentation shall be made in the client record to include, at a minimum: (A) notation of the client's physical and psychological well-being; (B) notation of the frequency, intensity and duration of the behavior which led to the intervention, and any precipitating circumstance contributing to the onset of the behavior; (C) the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used; (D) a description of the intervention and the date, time and duration of its use; (E) a description of accompanying positive methods of intervention; (F) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion,	V 521		

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V 521	Continued From page 20 physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions; (G) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and (H) signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the necessary documentation was in the client record when a restrictive intervention was utilized affecting one of two audited current clients (#3). The findings are: Review on 6/1/23 and 6/2/23 of client #3's record revealed: -16 year old male admitted 11/7/22. -Diagnoses included major depressive disorder, recurrent episode; and cannabis use, unspecified. -No documentation of all the required information for the restrictive intervention implemented on client #3. -No documentation for the length of the hold. -No documentation for the debriefing with the client. Interview on 6/1/23 client #3 stated: -He had lived at the facility for approximately 6 - 7 months. -He had been placed in a restrictive intervention by the Qualified Professional (QP) but could not recall the date.	V 521		

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V 521	Continued From page 21 -The restrictive intervention followed an argument with former client (FC) #5. -The Qualified Professional (QP) came from behind him and wrapped his arms around him during the intervention. Interview on 6/2/23 the QP stated: -He had been employed with the facility for approximately 1 - 1.5 years. -There was an incident in late March/early April 2023 in which client #3 and FC #5 got into a physical altercation requiring them to be separated. -FC #5 hit client #3 before they could be separated. -He "covered [client #3] so that he wouldn't get hit again." -He "held him and walked him to his room so he could calm down." -There had been no additional incidents requiring holds of any kind. Interview on 6/1/23 client #2 stated: -He had lived at the facility for a few months. -He had witnessed restrictive interventions being implemented on client #3 and former client #5 following a physical altercation on an unknown date. -Following the altercation, the QP "grabbed" client #3 and staff #1 "grabbed" FC #5. -There had been no other restrictive interventions witnessed. Interview on 6/2/23 the Owner/Licensed Professional stated:. -She was unaware of any restrictive interventions used in the last 6 months. -Moving forward, she would ensure all necessary documentation was completed following a restrictive intervention.	V 521		

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V 524	27E .0104(e12-16) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (12) The use of a restrictive intervention shall be discontinued immediately at any indication of risk to the client's health or safety or immediately after the client gains behavioral control. If the client is unable to gain behavioral control within the time frame specified in the authorization of the intervention, a new authorization must be obtained. (13) The written approval of the designee of the governing body shall be required when the original order for a restrictive intervention is renewed for up to a total of 24 hours in accordance with the limits specified in Item (E) of Subparagraph (e)(10) of this Rule. (14) Standing orders or PRN orders shall not be used to authorize the use of seclusion, physical restraint or isolation timeout. (15) The use of a restrictive intervention shall be considered a restriction of the client's rights as specified in G.S. 122C-62(b) or (d). The documentation requirements in this Rule shall satisfy the requirements specified in G.S. 122C-62(e) for rights restrictions. (16) When any restrictive intervention is utilized for a client, notification of others shall occur as follows: (A) those to be notified as soon as possible but within 24 hours of the next working day, to include: (i) the treatment or habilitation team, or its	V 524		

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V 524	Continued From page 23 designee, after each use of the intervention; and (ii) a designee of the governing body; and (B) the legally responsible person of a minor client or an incompetent adult client shall be notified immediately unless she/he has requested not to be notified. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to document notification of the treatment team and legally responsible person following a restrictive intervention as required, affecting 1 of 2 audited current clients (#3). The findings are: Review on 6/1/23 and 6/2/23 of client #3's record revealed: -16 year old male admitted 11/7/22. -Diagnoses included major depressive disorder, recurrent episode; and cannabis use, unspecified. -No documentation of the notification of parties legally responsible for client #3 following a restrictive intervention. Interview on 6/1/23 client #3 stated: -He had been placed in a restrictive intervention by the Qualified Professional (QP) but could not recall the date. -The restrictive intervention followed an argument with former client (FC) #5. -The Qualified Professional (QP) came from behind him and wrapped his arms around him during the intervention. -"Pretty much all the staff" come back and complete debrief following restraints. Interview on 6/2/23 the QP stated: -There was an incident in late March/early April 2023 in which client #3 and FC #5 got into a	V 524		

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V 524	Continued From page 24 physical altercation requiring them to be separated. -FC #5 hit client #3 before they could be separated. -He "covered [client #3] so that he wouldn't get hit again." -He "held him and walked him to his room so he could calm down." -There had been no additional incidents requiring holds of any kind. Interview on 6/1/23 client #2 stated: -He had witnessed restrictive interventions being implemented on client #3 and former client #5 following a physical altercation on an unknown date. -Following the altercation, the QP "grabbed" client #3 and staff #1 "grabbed" FC #5. -There had been no other restrictive interventions witnessed. Interview on 6/2/23 the Owner/Licensed Professional stated:. -She was unaware of any restrictive interventions used in the last 6 months. -Moving forward, she would ensure all necessary documentation was completed following a restrictive intervention.	V 524		
V 525	27E .0104(e17) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (17) The facility shall conduct reviews and reports	V 525		

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V 525	Continued From page 25 on any and all use of restrictive interventions, including: (A) a regular review by a designee of the governing body, and review by the Client Rights Committee, in compliance with confidentiality rules as specified in 10A NCAC 28A; (B) an investigation of any unusual or possibly unwarranted patterns of utilization; and (C) documentation of the following shall be maintained on a log: (i) name of the client; (ii) name of the responsible professional; (iii) date of each intervention; (iv) time of each intervention; (v) type of intervention; (vi) duration of each intervention; (vii) reason for use of the intervention; (viii) positive and less restrictive alternatives that were used or that were considered but not used and why those alternatives were not used; (ix) debriefing and planning conducted with the client, legally responsible person, if applicable, and staff, as specified in Parts (e)(9)(F) and (G) of this Rule, to eliminate or reduce the probability of the future use of restrictive interventions; and (x) negative effects of the restrictive intervention, if any, on the physical and psychological well-being of the client. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain documentation of all restrictive interventions on a log as required to include a debriefing with staff. The findings are: Review on 6/1/23 and 6/2/23 of facility records revealed no restrictive intervention log available for review.	V 525		

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V 525	Continued From page 26 Review on 6/1/23 and 6/2/23 of client #3's record revealed: -16 year old male admitted 11/7/22. -Diagnoses included major depressive disorder, recurrent episode; and cannabis use, unspecified. -No documentation of debriefing completed with the client. Interview on 6/1/23 client #3 stated: -He had lived at the facility for approximately 6 - 7 months. -He had been placed in a restrictive intervention by the Qualified Professional (QP) but could not recall the date. -The restrictive intervention followed an argument with former client (FC) #5. -The Qualified Professional (QP) came from behind him and wrapped his arms around him during the intervention. -"Pretty much all the staff" come back and complete debrief following restraints. Interview on 6/2/23 the QP stated: -He had been employed with the facility for approximately 1 - 1.5 years. -There was an incident in late March/early April 2023 in which client #3 and FC #5 got into a physical altercation requiring them to be separated. -FC #5 hit client #3 before they could be separated. -He "covered [client #3] so that he wouldn't get hit again." -He "held him and walked him to his room so he could calm down." -He went back following the hold and talked to both client #3 and FC #5 to "get to the root" of the incident. -There had been no additional incidents requiring holds of any kind.	V 525		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-170	A. BUILDING: _____ B. WING _____	R 06/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAPARRAL YOUTH SERVICES, LLC	5973 MCLEOD DRIVE MAXTON, NC 28364

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V 525	Continued From page 27 Interview on 6/1/23 client #2 stated: -He had lived at the facility for a few months. -He had witnessed restrictive interventions being implemented on client #3 and former client #5 following a physical altercation on an unknown date. -Following the altercation, the QP "grabbed" client #3 and staff #1 "grabbed" FC #5. -There had been no other restrictive interventions witnessed. Interview on 6/2/23 the Owner/Licensed Professional stated:. -She was unaware of any restrictive interventions used in the last 6 months. -Moving forward, she would ensure all necessary documentation was completed following a restrictive intervention.	V 525		