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V 000	INITIAL COMMENTS An annual and complaint survey was completed on September 7, 2023. Two complaints were substantiated (intake #NC00206305 and #NC00204561) and one complaint was unsubstantiated (intake #NC00206211). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1800 Intensive Residential Treatment for Children and Adolescents. This facility is licensed for 12 and currently has a census of 9. The survey sample consisted of audits of 7 current clients and 1 former client.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (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	V 108		

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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.
(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.

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to provide training to meet the client's mh/dd/sa needs as specified in the treatment/habilitation plan affecting 10 of 13 current audited staff (#1, #2, #3, #5, #9, #10 , #11, House Manager (House Manager and Qualified Professional (QP) #1, #2) and 3 of 5 Former Staff (FS) (#13, #14 and #15). The findings are:

Review on 08/28/23 of staff #1's personnel record revealed:
-Date of Hire: 04/24/23.
-No training to meet the needs of the clients.

Review on 08/25/23 of staff #2's personnel file revealed:
-Date of hire: 08/11/23.
-No training to meet the needs of the clients.

Review on 08/28/23 of staff #3's personnel record revealed:
-Date of Hire: 06/29/23.

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-No training to meet the needs of the clients.

Review on 08/28/23 of staff #5's personnel record revealed:
-Date of Hire: 06/14/23.
-No training to meet the needs of the clients.

Review on 08/25/23 of staff #9's personnel record revealed:
-Date of Hire: 07/19/23.
-No training to meet the needs of the clients.

Review on 08/28/23 of staff #10's personnel record revealed:
-Date of Hire: 06/15/20.
-No training to meet the needs of the clients.

Review on 08/28/23 of staff #11's personnel record revealed:
-Date of Hire: 06/05/23.
-No training to meet the needs of the clients.

Review on 08/25/23 of FS #13 personnel file revealed:
-Date of hire: 06/28/23.
-Date of seperation: 08/22/23.
-No training to meet the needs of the clients.

Review on 08/25/23 of FS #14's personnel file revealed:
-Date of hire: 07/05/23.
-No date of seperation documented.
-No training to meet the needs of the clients.

Review on 08/25/23 of FS #15's personnel file revealed:
-Date of hire: 06/13/23.
-Date of separation: 07/26/23.
-No training to meet the needs of the clients.

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Review on 08/25/23 of House Manager's personnel file revealed:
-Date of hire: 04/24/23.
-No training to meet the needs of clients.

Review on 08/28/23 of the QP #1's personnel record revealed:
-Date of Hire: 07/17/23.
-No training to meet the needs of the clients.

Review on 08/28/23 of QP #2's personnel record revealed:
-Date of Hire: 05/31/23.
-No training to meet the needs of the clients.

Interview on 08/25/23 the Human Resources Director stated she completed the orientation to the facility and the QPs provided training on the clients at the facility.

Interview on 08/31/23 FS #14 stated:
-She worked at the facility for approximately 1 and 1/2 months.
-She had training in restraints and cardiopulmonary resuscitation.
-She did not have any training in mental health.
-There should have been "more training" at the facility.

Interview on 08/25/23 a local police detective stated:
-She was at the facility on 08/22/23.
-Several police officers had gone to the facility and "we had to restore order" at the facility.
-She witnessed staff arguing with the clients.
-She was concerned if the staff had adequate training to meet the needs of the clients.

Interview on 09/07/23 the Residential Director/Crisis Prevention Institute Instructor

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V 108	Continued From page 4 stated the QPs should provide training for the staff at the facility.	V 108		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (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: (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. (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.	V 111		

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V 111	Continued From page 5 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure an admission assessment was completed for 1 of 7 audited clients (#8). The findings are: Review on 08/24/23 of client #8's record revealed: -10 year old male. -Admitted on 08/07/23. -Diagnoses of Reactive Attachment Disorder of Childhood, Attention Deficit Hyperactivity Disorder combined type, Enuresis, Conduct Disorder, Posttraumatic Stress Disorder and Oppositional Defiant Disorder. -No evidence of an admission assessment. Interview on 08/30/23 client #8 stated: -He was admitted 3 or 4 weeks ago. (08/07/23) Interview on 08/24/23 the Lead Qualified Professional stated: -She worked at the facility about 2 weeks. -She was in the process of organizing the client records. -She did not have an admission assessment for client #8.	V 111		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the	V 112		

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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 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.

This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to obtain written consent or agreement for the treatment/habilitation or service plan by the legally responsible person for 3 of 7 audited clients (#2, #3 and #5) The findings are:

Finding # 1
Review on 08/24/23 of client #2's record revealed:

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V 112	Continued From page 7 -13 year old male. -Admitted on 05/04/23. -Diagnoses of Oppositional Defiant Disorder and Bipolar Unspecified. -Treatment plan dated 04/25/23 had no signature page to include consent from the legal guardian. Interview on 08/30/23 client #2 stated: -He was admitted to the facility 4 months ago. -His grandparents were his legal guardians. Finding # 2 Review on 08/29/23 of client #3's record revealed: -12 year old male. -Admitted on 05/02/23. -Diagnoses of Conduct Disorder, Attention Deficit Hyperactivity Disorder combined and Disruptive Mood Dysregulation Disorder. -Treatment plan dated 06/08/23 had no signature page to include consent from the legal guardian. Interview on 08/30/23 client #3 stated: -He was admitted about 4 months ago. -His guardian was a local department of social services. Finding #3 Review on 08/24/23 of client #5's record revealed: -13 year old male. -Admitted on 05/06/23. -Diagnoses of Disruptive Mood Dysregulation Disorder, Conduct Disorder, childhood onset type, Intellectual Developmental Disability, Mild, Child Physical Abuse, Child Psychological Abuse, Child Neglect. -Treatment plan dated 05/06/23 had no signature page to include consent from the legal guardian.	V 112		

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V 112	Continued From page 8 Interview on 08/24/23 client #5 stated: -He did not know how long he had lived at the facility. -His grandmother was his legal guardian. Interview on 09/05/23 the Lead Qualified Professional revealed: -She had only worked at the facility for approximately 2 weeks. -She worked all weekend at the facility organizing all the records. -She was "waiting on the signature pages" for the Person-Centered Plans (PCP). During interview on 09/7/23 the Residential Director/Crisis Prevention Institute Instructor revealed: -She understood the PCPs needed guardian consents.	V 112		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (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. (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	V 118		

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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, observation and interviews the facility failed to ensure medications were administered as ordered by a physician and MARs were kept current affecting 3 of 3 audited clients (#2, #3 and #5) whose medications were reviewed. The findings are:

Finding #1
Review on 08/24/23 of client #2's record revealed:
-13 year old male.
-Admitted on 05/4/23.
-Diagnoses of Oppositional Defiant Disorder and Bipolar Unspecified.

Review on 08/24/23 and 09/7/23 of client #2's signed physician orders dated 05/24/23 revealed:
-Metformin 500 milligram (mg) twice daily with meals increased on 06/07/23 1.5 tablets twice

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V 118	Continued From page 10 daily with meals. (Diabetes) -Olanzapine 10 mg three times daily. (Bipolar) -Propranolol 40 mg three times daily for impulse control. -Senna Tab 8.6 mg 2 tablets every morning. (Constipation) -Therems-M Tablet 1 time a day with lunch. (Supplement) Review on 08/24/23 of client #2's MARs from 06/01/23 - 08/24/23 revealed no documentation for medication being administration for the following medications: -Metformin 500 mg on 06/10/23 (12pm) and 06/11/23 (6pm) and 08/13/23 (6pm). -Olanzapine 10 mg at 2pm on 07/12/23, 07/16/23 and 07/24/23 and 8pm on 08/04/23. -Propranolol 40 mg at 2pm on 07/02/23, 07/12/23, 07/16/23, 07/24/23 and at 8pm on 08/10/23-08/12/23. -Senna Tab 8.6 on 08/22/23. -Therems-M Tablet on 07/24/23. Interview on 08/30/23 client #2 stated: -He took his medications every morning, afternoon and night. -He had not missed any medications. Finding #2 Review on 08/29/23 of Client #3's record revealed: -12 year old male. -Admitted on 05/02/23. -Diagnoses of Conduct Disorder, Attention Deficit Hyperactivity Disorder (ADHD) combined and Disruptive Mood Dysregulation Disorder. Review on 08/29/23 and 09/07/23 of client #3's signed physician orders revealed: 05/06/23	V 118		

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-Clonidine 0.1 mg at bedtime. (ADHD)
-Risperidone 1 mg twice daily. (Bipolar)
-Vyvanse 50 mg every morning. (ADHD)
05/31/23
-Trazodone 50 mg at bedtime for sleep.

Review on 08/29/23 of client #3's MARs from 06/01/23 - 08/24/23 revealed:
Blanks
-Clonidine on 07/14/23.
-Risperidone 1 mg on 07/04/23 (8am) and 07/14/23 (8pm).
-Trazodone 50 mg on 07/03/23, 07/10/23 and 07/14/23.
-Vyvanse 50 mg was not administered on 07/03/23 - 07/06/23.

Interview on 08/30/23 client #3 stated:
-He received his medications daily.

Finding #3
Review on 08/24/23 of client #5's record revealed:
-13 year old male.
-Admitted on 05/06/23.
-Diagnoses of Disruptive Mood Dysregulation Disorder, Conduct Disorder, childhood onset type, Intellectual Developmental Disability, Mild, Child Physical Abuse, Child Psychological Abuse and Child Neglect.

Review on 08/24/23 and 09/01/23 of client #5's signed physician orders revealed:
05/10/23
-Cetirizine 10mg Take 1 tablet by mouth once daily. (Allergy)
-Multivitamin Take 1 tablet by mouth daily. (supplement)
08/18/23
-Clonidine 0.1mg Take 1 tablet by mouth daily at

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V 118	Continued From page 12 bedtime. (ADHD) 06/08/23 -Divalproex 250mg Take 2 tablets by mouth daily. (Seizures) -Hydroxyzine 50mg Take 1 tablet by mouth at bedtime. (Anxiety) -Slow Release Iron 45mg Take 1 tablet by mouth every morning. (Supplement) 07/11/23 -Invega 6mg Take 1 tablet by mouth every morning. (Antipsychotic) 07/07/23 -Levothyroxine 25mg Take 1 tablet by mouth every morning on an empty stomach. (Hypothyroidism) -Vitamin C Tablet 250mg Take 1 tablet by mouth every morning. (Supplement) -Vitamin D3 50mcg Take 1 capsule once daily. (Supplement) Review on 08/24/23 of client #5's MAR's from 06/01/23 - 08/24/23 revealed no documentation for medication administration for the following medications: -Cetirizine 10mg- 06/14/23-06/30/23, 08/2/23-08/14/23, 08/23/23. -Multivitamin-06/14/23-06/30/23, 08/2/23-08/14/23. -Clonidine 0.1mg-06/13/23-06/30/23, 08/1/23-08/13/23. -Divalproex 250mg-07/23/23, 08/2/23-08/14/23. -Hydroxyzine 50mg-06/13/23-06/30/23, 08/01/23-08/13/23, 08/15/23. -Levothyroxine 25mg-08/2/23-08/14/23. -Slow-Release Iron 45mg-06/14/23-06/30/23, 08/2/23-08/14/23, 08/23/23. -Vitamin C 250mg-06/14/23, 08/2/23-08/14/23, 08/23/23. -Vitamin D3 50mcg-08/02/23-08/14/23, 08/23/23.	V 118		

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During interview on 08/24/23 client #5 revealed:
-He received his medication daily.

During interview on 09/7/23 the Residential Director/Crisis Prevention Institute Instructor revealed:
-She understood the MARs needed to be signed and given explanations as to why the medication was not given.

Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician.

V 132 — G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection — V 132

G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY
(g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes:
a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.
b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.
c. Misappropriation of the property of a healthcare facility.
d. Diversion of drugs belonging to a health care

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facility or to a patient or client.
e. Fraud against a health care facility or against a patient or client for whom the employee is providing services).
Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure the Health Care Personnel Registry (HCPR) was notified of all allegations against health care personnel and failed to ensure all alleged allegations were investigated for 4 of 13 audited current staff (Qualified Professional (QP) #2, staff #5, staff #6, staff #11) and 3 of 5 audited Former Staff (FS) (#12, #13, #14) of. The findings are:

Review on 09/07/23 of the North Carolina Incident Response Improvement System (IRIS) for July 1, 2023 thru September 7, 2023 revealed no level III reports submitted by the facility.

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Review on 09/07/23 of facility records revealed no documentation the HCPR was notified of an allegation of abuse against staff #5 #6, #11, Qualified Professional (QP) #2 and former staff (FS) #12, #13, and #14.

Review on 08/24/23 of client #1's record revealed:
-15 year old male.
-Admission date of 06/16/23.
-Diagnoses of Adjustment Disorder, with mixed disturbance of emotions and conduct, Oppositional Defiant Disorder and Mild Intellectual Developmental Disability.

Review on 08/24/23 of client #5's record revealed:
-13 year old male.
-Admitted on 5/6/23.
-Diagnoses of Disruptive Mood Dysregulation Disorder, Conduct Disorder, childhood onset type, Intellectual Developmental Disability (IDD), Mild, Child Physical Abuse, Child Psychological Abuse and Child Neglect.

Finding #1:
Review on 08/24/23 of an incomplete facility level I incident report for client #5 revealed:
-Date and time of incident: 07/20/23 at 8:30pm.
-Description of incident/Accident: "[Client #5] started to get aggressive towards 2 other clients. Putting his arms around their necks, stating he was going to kill them. We attempted to calm him down for about 10 min (minutes) but he just kept escalating to more aggressive behavior physically to the same 2 clients. Staff (unknown staff) decided to remove [Client #5] to his room to separate him from the other clients for their safety and his own. Myself and Ms [Staff #6] & Ms [QP

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#2] decided to drag client to his room for safer detaining but when we got to his room, he refused to go in and started being physically aggressive so at that point we detained him on the floor. I (FS #14) detained his right arm, [QP #2] detained left arm and Ms [Staff #6] his feet. We tusselled w/ (with) [Client #5] for about 20 mins. He banged his head on floor & wall. He tried to punch and kick Ms [QP #2]. He accused ms [QP #2] of hurting his private part and sitting on his arm. I did not witness that."

Finding #2:
Review on 08/25/23 of a facility surveillance video dated 08/22/23 revealed:
-The video did not offer audio.
-Approximately 1:59am, QP #1 left the facility.
-Staff #2 and FS #13 present with 6 clients.
-At 12:27pm, client #5 dragged client #8 by his feet out of his room. FS #13 stood still in the hallway with clients and watched. Once released by client #5, client #8 returned to his room. Client #5 had a face to face interaction with FS #12 before she directed him in the opposite direction and followed.
-12:29pm Client #5 went into client #8's bedroom and FS #13 went into client #8's bedroom and pushed client #5 about his body across the hall and into his (client #5) bedroom before client #5 ran out of his own bedroom while FS #13 was inside. Client #5 ran into the kitchen.
-12:32 - FS #13 gathered her food and drink and left the facility. FS #12 arrived from the sister facility.
-FS #12 removed client #5 from the kitchen and walked him to the hall. Client #5 fell to the ground and FS #12 picked client up under his arms with the client's back to the staff's and dragged client #5 into his bedroom.

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V 132	Continued From page 17 Finding #3: Review on 09/07/23 of a North Carolina IRIS Report for client #1 revealed: -Date and time of the incident: 08/18/23 at 4:30pm. -"Describe the cause of this incident, (the details of what led to this incident). [Client #1] was complaining about [Client #5]. [Client #1] was upset because he felt it was not fair that [Client #5]'s punishment was removed due to the fact that the previous day [Client #5] put [Client #1] in a chokehold. [Client #5] overheard [Client #1] saying these things and began arguing with him. [Client #5] initiates the fight by saying "then do something." [Client #1] grabs a broom, as the consumers are in the middle of doing chores. [Client #5] grabs the dustpan and hits [Client #1]. Both consumers release the objects and began fist fighting. Staff A (unknown staff) and Staff B (unknown staff) rush to break them apart. They were refusing to calm down so staff C (unknown staff) was called from the front building. [Client #1] was still refusing to calm down so staff C placed him in a CPI (Crisis Prevention Hold) hold. He is eventually able to calm down." Review on 08/23/23 of facility surveillance video dated 08/18/23 revealed: -4:08pm client #1 quickly stood up and left from the common area table and staff #5 and staff #11 followed up. -Client #1 went in the opposite direction of the hall where his bedroom was located. -Staff #11 wrapped his arm around client #1 waist and picked him up off his feet and headed down the hall before they both fell to the floor. -After getting off the floor briefly, staff #11 continued to struggle with client #1 before falling to the floor again. -While client #1 was still on the ground, staff #11	V 132		

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V 132	Continued From page 18 stood up and grabbed of client #1's ankles and pulled him down the hall to his bedroom as staff #5 followed. -Staff #5 stood at client #1's bedroom door while staff #11 went into client #1's bedroom. Interview on 08/29/23 client #1 revealed: -He had been dragged by his feet and arms by staff. -QP #2 was the staff that had dragged him. -She was pulling him by his legs and Staff #17 had him by his arms. -Staff #17 was the maintenance person. Interview on 09/05/23 the Residential Director/Crisis Prevention Institute Instructor stated: -The incidents with client #5 on 7/20/23, involving FS #14 and FS #15, and on 8/22/23, which involved FS #12 and FS #13 of the client being dragged were considered to be "abusive." -The facility should follow their policy and procedures for abuse allegations. -The facility was working on these issues.	V 132		
V 301	27G .1801 Intensive Res. Tx. Child/Adol - Scope 10A NCAC 27G .1801 SCOPE (a) An intensive residential treatment facility is one that is a 24-hour residential facility that provides a structured living environment within a system of care approach for children or adolescents whose needs require more intensive treatment and supervision than would be available in a residential treatment staff secure facility. (b) It shall not be the primary residence of an individual who is not a client of the facility. (c) The population served shall be children or	V 301		

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V 301	Continued From page 19 adolescents who have a primary diagnosis of mental illness, severe emotional and behavioral disorders or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for acute inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to an intensive integrated treatment setting; and (2) treatment in a locked setting. (e) Services shall be designed to: (1) assist in the development of symptom and behavior management skills; (2) include intensive, frequent and pre-planned crisis management; (3) provide containment and safety from potentially harmful or destructive behaviors; (4) promote involvement in regular productive activity, such as school or work; and (5) support the child or adolescent in gaining the skills needed for reintegration into community living. (f) The intensive residential treatment facility shall coordinate with other individuals and agencies within the child or adolescent's system of care. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide containment and safety from potentially harmful and destructive behaviors	V 301		

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affecting 2 of 7 audited current clients (#1 and #5) and 1 of 1 audited former client (FC) (FC #10) and the facility failed to coordinate with other individuals and agencies within the child or adolescent's system of care affecting 1 of 7 audited current clients (#3). The findings are:

Finding #1:
Below are incidents of where the facility failed to ensure safety from harmful and destructive behaviors for Client #5.

Review on 08/24/23 of client #5's record revealed:
-13 year old male.
-Admitted on 05/06/23.
-Diagnoses of Disruptive Mood Dysregulation Disorder (DMDD), Conduct Disorder (CD), childhood onset type, Intellectual Developmental Disability (IDD), Mild, Child Physical Abuse, Child Psychological Abuse and Child Neglect.
-Person-Centered Plan dated 05/06/23: "[Client #5] will reduce frequent and excessive anger outbursts, erratic mood swings, and suicidal and homicidal ideations..."

A. Review on 08/25/23 of a North Carolina Incident Response Improvement System (IRIS) report for client #5 revealed:
- Date and time of the incident: 06/13/23 at 2:40pm.
- Provider Comments: "[Client #5] went outside and stated that he wanted something good to eat, before already stating that he was going to kill himself. [Client #5] placed his fingers in ant poison outside in the consumers enclosed play area. [Client #5] attempted to place his fingers in his mouth. [Client #5] was monitored so that he was not able to place his fingers in his mouth. The Lead QP (Qualified Professional), [Former

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V 301	Continued From page 21 Lead QP], the 1st Shift QP, [Former QP #3], and the 2nd shift QP, [QP #2] were informed. After, the 1st shift QP, [Former QP #3] quickly outside with hand sanitizer to clean [Client #5] hands promptly. Upon noticing that there was only one hand with poison on the fingers, the QP successfully cleaned the hand. [Client #5] quickly reached down into a pile of poison on the ground with his other hand and placed those fingers directly into his mouth before being able to be stopped. He ran into the facility to an open room and laid on the bed. [Client #5] tried to close the door, but staff (unknown staff) was able to stop the door from cloding. [Former QP #3] and [QP #2] lifted [Client #5] off the bed and escorted him to the van to get him to the hospital." -"Describe the cause of this incident, (the details of what led to this incident). [Client #5] went outside and stated that he wanted something good to eat, before already stating that he was going to kill himself. [Client #5] placed his fingers in ant poison outside in the consumers enclosed play area.[Client #5] attempted to place his fingers in his mouth. [Client #5] was monitored so that he was not able to place his fingers in his mouth. The Lead QP, [Former Lead QP], the 1st Shift QP, [Former QP #3], and the 2nd shift QP , [QP #2] were informed. After, the 1st shift QP, [Former QP #3] quickly outside with hand sanitizer to clean [Client #5] hands promptly. Upon noticing that there was only one hand with poison on the fingers, the QP successfully cleaned the hand. [Client #5] quickly reached down into a pile of poison on the ground with his other hand and placed those fingers directly into his mouth before being able to be stopped. He ran into the facility to an open room and laid on the bed. [Client #5] tried to close the door, but staff (unknown staff) was able to stop the door from closing. [Former QP #3] and [QP #2] lifted	V 301		

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[Client #5] off the bed and escorted him to the van to get him to the hospital."
-"Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. Staff and consumers will continue to be monitored and the therapist will assist."
-Completed by Former QP #3.

Review on 09/07/23 of the hospital report dated 06/13/23 revealed:
-"Reason for Consult: Ingestion.
-Patient Assessment: This is a 13 yo (year old) male who was just discharged from [Hospital] on 06/12 @ 1949 (7:49pm) back to group home. He returned the following day on 6/13 @ 1513 (3:13pm) accompanied by GH (group home) staff (unknown staff) after ingesting fire ant poison.
-Patient seemed fine most of the day (calm, cooperative). At one point, he came into the director's office and said he wanted to harm himself. He was laughing as he said this...Later, patient, other residents, and staff (unknown staff) went outside. Patient spotted some white substance on the ground and kept trying to touch it. Staff (unknown staff) redirect him several times to stop doing so. He eventually got some of the substance on his finger and licked it. He said it tasted bad. [Former Lead QP] contacted the maintenance man who stated that the substance was fire ant poison..."

Interview on 08/29/23 staff #1 revealed:
-She had not seen the staff put the ant poision out in a while.
-The ant poision was outside in the courtyard.
-She told other staff that client #5 was trying to put the ant poision in his mouth.
-Former QP #3 went outside and client #5 licked

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V 301	Continued From page 23 the poision. -She had client #5 clean his hands and sanitize his hands. -"Poision Control was called." -The ant poision was a powder and "he kept putting his fingers in it (powder) and licking it." B. Review on 08/25/23 of a North Carolina IRIS report for client #5 revealed: -Date and time of incident: 06/12/23 at 8:00 (am). -Provider Comments: "[Client #5] stated he was still hungry and asked staff (unknown staff) for more food but there wasn't anymore food left. [Client #5] then went into a behavior and grabbed two tubes of [Brand] Mint toothpaste from his room and began ingesting both tubes of toothpaste. [Client #5] then began vomiting due to the ingestion of the toothpaste. He then grabbed the shampoo and ingested the shampoo/shower gel. Staff (unknown staff) was able to get the bottle from [Client #5] before [Client #5] could ingest a large amount. [Client #5] then went into his room and started licking the deodorant he had hidden in his closet. QP was able to calm [Client #5] down by offering him yogurt and cereal. QP (unknown QP) was on the phone with Poison Control who gave the directive of the yogurt and dairy from the milk due to the ingesting of aforementioned items." -"Describe the cause of this incident, (the details of what led to this incident). [Client #5] stated that he was hungry and wanted something to eat." -"Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. Staff and consumers will continue to be monitored and the therapist will assist." -Completed by Former QP #3.	V 301		

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C. Review on 08/25/23 of an incomplete facility level I incident report for client #5 revealed:
-Date and time of incident: 06/12/23 at 8:50am.
-"[Client #5] stated he had a secret stash in his room, after the QP [Former QP #3] and [Former Lead QP] took [Client #5] out of the facility staff (unknown staff) went into [Client #5's] room and searched through his clothes and found a sock with screws in it. Staff (unknown staff) continued to search his closet and clothes and confiscated anything that could cause harm to himself and others."
-Completed by FS #19.

D. Review on 09/07/23 of a North Carolina IRIS report for client #5 revealed:
-Date and time of incident: 08/22/23 at 2:00pm.
-"Describe the cause of this incident, (the details of what led to this incident). Consumer [Client #5] was sent to room for his behaviors and he did not want to go so he started screaming and cursing at the consumers and the staff (unknown staff). He was using very fowl words and threatening staff (unknown staff) and the other consumers (unknown clients). He threatened a police officer as well.
- Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. The incident could have been prevented if the staff would have stepped back and let the officers do their job. The staff needs to stop arguing with the consumers and screaming at them to stop something. In service training will be provided by the corporate office again and also in the facility to be sure that the staff understand not to raise their voices when the consumer has already been triggered into a behavior."
-Completed by Lead QP

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V 301	Continued From page 25 E. Review on 08/24/23 of an IRIS report for client #5 revealed: -Date and time of incident: 05/19/23 at 3:30pm. -"Provider Comments: [Client #5] became upset over the game. The game sent [Client #5] into a behavior. [Client #5] threatened staff (unknown staff) and spit on the floor. [Client #5] tried to harm himself. [Client #5] broke the plexiglass in his room. During this time, [Client #5] gets into a physical altercation with a peer (unknown client). [Client #5] became mad and broke the back door to the courtyard. [Client #5] has to be removed by the police. Police was at the facility and [Client #5] tried hitting staff (unknown staff) with a stick. [Client #5] was then removed by police. -Describe the cause of this incident, (the details of what led to this incident). [Client #5] became upset over the game. -Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. Staff will continue to monitor these incidents to ensure the safety of consumers and continue to monitor incidents of inappropriate behavior of staff and consumers. The therapist will assist." -Completed by Former QP #3. F. Review on 08/24/23 of a North Carolina IRIS report for client #5 revealed: -Date and time of incident: 05/19/23 at 8:30am. -"Provider Comments: [Client #5] and peer were arguing back and forth. They were told to separate and stop multiple times. [Client #5] got up and started approaching peer (unknown client) with his hand raised. Staff (unknown staff) stood in front of peer (unknown client) with their hand out to stop [Client #5]. [Client #5] swung and hit	V 301		

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staff (unknown staff) shoulder and peer's face."
-"Describe the cause of this incident, (the details of what led to this incident). [Client #5] and peer (unknown client) were arguing at one another as they were both upset at one another."
-"Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. Staff will continue to monitor these incidents to ensure the safety of consumers and continue to monitor incidents of inappropriate behavior of staff and consumers. The therapist will assist."
-Completed by Former QP #3.

Finding #2:
Below are incidents of were the facility failed to ensure safety from harmful and destructive behaviors for FC #10:

Review on 09/01/23 of FC #10's record revealed:
-16 year old male.
-Admission date of 06/12/23.
-Discharge date of 07/03/23.
-Diagnoses of Disruptive Mood Dysregulation Disorder, Mild Intellectual Disability, Attention Deficit Hyperactivity Disorder and Conduct Disorder

A. Review on 09/07/23 of an IRIS report for FC #10 revealed:
-Date of incident: 06/20/23
-"Describe the cause of this incident, (the details of what led to this incident). Client (FC #10) became upset because he was asked to take a shower. Then he ran and kicked the door open and left the facility. The staff (unknown staff) called the QP (unknown QP) and was instructed to call the police. He return back to the facility on

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his own. He made threats to staff (unknown staff) stating he is going to kill everyone. Staff (unknown staff) was encouraging him to take a bath, he refused. He broke back out by kicking the door down and then he went and got a brick threatening to bust out the staff (unknown staff) window. He came back in started braking the kitchen door so he could get a knife to stab us (unknown staff). He was not able to get the break then he threw the brick at staff (unknown staff). Staff (unknown staff) was able to move out the way. The police arrived to the facility. Staff (unknown staff) was instructed to give PRN (as needed). He took the PRN and then went to bed. No issues the rest of the night.
-Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. Encourage staff to continue to de-escalate the situation and make sure staff offer PRN when client looks agitated. Continue to use CPI (Crisis Prevention Institute) Hold to prevent any harm towards himself and staff."
-Completed by Former Lead QP

B. Review on 09/07/23 of an IRIS report for FC #10 revealed:
-Date of incident: 06/24/23.
-"Describe the cause of this incident, (the details of what led to this incident). Client (FC #10) was horse playing with his peer. He was grabbing his peer from the back with arms wrapped around another peer. Staff (unknown staff) redirected him several times stop horse playing with his peers and let him go. Client refused. Staff (unknown staff) prime open hands until he released the peer. Then he ran to the front picked up play station and made threats to throw the play station down. Then he ran to back door with play station

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game. Staff (unknown staff) was able to get the play station game. While walking up front to put the play station up, he started putting his hand in staff (unknown staff) face. Staff (unknown staff) redirected him to stop. Then he became aggressive towards staff (unknown staff) by hitting staff (unknown staff) several times. Staff (unknown staff) tried to place him in a CPI Hold before staff (unknown staff) could place him in a CPI hold, he spit into the staff (unknown staff) face. Staff (unknown staff) stepped away from the client. Then the client ran broke out the door and then he went outside took a brick and threw it through staff (unknown staff) window and then he started walking away towards the road and made a left. QP instructed staff (unknown staff) to call the police. Police found him and was brought back to the facility. He stated he did not want to be at the facility and want to go to the hospital. He was taken to the hospital to get further evaluated.
-Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. Continue to encourage client to use coping skills to assist with frustration and anger outburst. Continue to offer PRN to help with agitation."
-Completed by Former Lead QP.

C. Review on 09/07/23 of an IRIS report for FC #10 revealed:
-Date of incident: 07/01/23.
-"Describe the cause of this incident, (the details of what led to this incident). [FC #10] refused to leave the kitchen after staff 2 (unknown staff) redirected him several times to leave out the kitchen. [FC #10] refused and became upset and busted through both doors to get outside of the facility. While threatening to buss the windows of

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the staff (unknown staff) cars with two wooden pieces. The police was called. The police came to the facility and was able to get him to place down the wooden pieces and get him back inside the facility. That was around 7:00 pm. [FC #10] was redirected to go to bed due to it was bedtime. He refused to go to sleep around 9:30pm and continued too buss in the kitchen. He was able to get to a knife staff (unknown staff) redirected him to place the knife down. He refused and cut a watermelon. Staff (unknown staff) redirected him again to place the knife down and exit the kitchen. He was able to exit the kitchen. Around 11pm when next shift came on. While staff 3 (unknown staff) was in the kitchen to complete dishes, he rushes in the kitchen and grabs half the watermelon, He started eating it sloppy and rubbing the juice all over his stomach. He poured the juice on his peer (unknown client) while he was sleeping. He threw the remainder of the watermelon juice on another peer (unknown client) that was sleeping and then he poured water on himself. Staff (unknown staff) was trying to stop him from going into the rooms of the peer and he was pushing threw staff (unknown staff) every time."
- "Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. Continue to deescalate the situation by talking to him in a calm voice. Also, make sure PRN is offered soon as staff sees he is becoming agitated or frustrated. Also, make sure staff followed the CPI Intervention."
-Completed by Former Lead QP.

Finding #3:
Below are incidents of were the facility failed to ensure safety from harmful and destructive

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behaviors for Client #1:

Review on 08/24/23 of client #1's record revealed:
-15 year old male.
-Admission date of 06/16/23.
-Diagnoses of Adjustment Disorder, with mixed disturbance of emotions and conduct, Oppositional Defiant Disorder and Mild Intellectual Developmental Disability.

A. Review on 08/24/23 of an incomplete facility level I incident report for client #1 revealed:
- Date and time of incident: 08/05/23 at 5:10pm.
- Description of incident/accident: "At around 5:10pm, I (QP #2) heard a loud bang at the door. Ms [Staff #16]comes to my door to inform me that [Client #1] has broken out of the building. I walk down the road to see that [Client #1] has made a right of the campus. Mr. [Staff #17] calls the police. I am on the phone with police explaining what has happened and where he went off the campus. 5 mins (minutes) later, [Staff from sister facility] brings [Client #1] back after I got off the phone with Mrs. [Former Lead QP] after i got off the phone with the police. At around 5:30pm, [Client #1] was back in his room and he was placed in a CPI hold due to punching and kicking staff (unknown staff) and having verbal threats towards staff (unknown staff) and other consumers, The nurse was called about this. He refused to take any PRNs that was offered to him. Every 30 mins [Client #1] was reassessed for pain and bruising. 2 hrs (hours) later at 7:30pm, [Client #1] agreed to take a PRN, Saphris. After 30 mins after, [Client #1] was still aggressive Mrs. [Former Lead QP] arrived on scene @ 7:40pm. [Client #1] also punched another consumer, [Client #2]. [Client #2] was told by staff (unknown staff) to stay away from [Client #1], but [Client #2]

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ignored our warning and got close to [Client #1] to try to calm him, and that is when [Client #1] punched him in the face. No visible marks or bruise found on [Client #2]."
-Completed by QP #2.

B. Review on 09/07/23 of an IRIS report for client #1 revealed:
-Date and time of incident: 08/30/23 at 8:10pm.
-"Describe the cause of this incident, (the details of what led to this incident). [Client #1] was sitting in the front living area with the other consumers. He gets up to look down the hallway and when he sees [Client #6], he exclaims that ,it is not fair. [Client #6] was down the hallway eating his snack in order to avoid conflict with other consumers. [Client #1] claims he's going to sleep and walks down the hallway. He walks down only to begin arguing with [Client #6]. [Client #1] takes [Client #6]'s cup and runs. [Client #6] chases after [Client #1]. Staff (unknown staff) was able to intervene but [Client #1] was still refusing to calm down. [Client #6] was told to go to his room. [Client #1] runs into [Client #6]'s room and slaps [Client #6]. [Client #1] begins trying to disturb other consumers as they are sleeping. He threw shoes at two consumers while they were sleeping. Staff (unknown staff) was still trying to calm him down at this point but then [Client #1] starts throwing clothes at staff (unknown staff). He goes back up front to grab a pencil and pen, which he throws at the Qualified Professional (unknown QP). [Client #1] was given a PRN and the police were notified."
-"Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. Staff will continue to monitor clients 24/7. They will promote methods of

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de-escalation."

C. Review on 09/07/23 of an IRIS report for client #1 revealed:
-Date and time of incident: 09/02/23 at 9:30pm.
-"Describe the cause of this incident, (the details of what led to this incident). [Client #1] was agitating everyone in the facility. He proceeds to kick down the doors and run outside. He throws rocks at staff (unknown staff) and their cars. When he runs back into the facility, [Client #4] asks [Client #1] to 'chill out.' [Client #1] replies to this statement by saying, 'Or what? If you hit me, I'm going to hit you back. [Client #4] tells, 'Well hit me.' [Client #1] tells [Client #4] to 'hit me.' The two get into a physical altercation. Staff (unknown staff) is able to break them up. [Client #1] hits staff (unknown staff) one in the process.
-Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. Staff will continue 24/7 supervision. They will promote methods of de-escalation."

Finding #4
Below are police reports where the police had to assist the facility to ensure clients were maintained in a safe environment from harmful and destructive behaviors:

-05/17/23 at 10:31am No name identified:
"BUILD (ing) B AT THE BACK...Chief Complaint: Suicide threatened
Questions: 1. He is INTENDING SUICIDE. 2. It`s not known but possible that he is violent. 3. He does not have a weapon. 4. He is responding normally (completely alert). 5. He has not done anything to injure himself. 6. He is thinking about injuring himself. 7. The patient is outside of the

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same structure. 8. Agency has chosen to send now and end questioning."
-05/18/23 at 9:09am No name identified-"...To bring leg shackles...Client being very aggressive with staff (unknown staff)..."
-05/22/23 at 4:11pm No name identified-"Caller ADVD (advised) Male JUV (juvenile) on scene causing a disturbance...caller ADVD he tried to get knife out of kitchen same (name) is [Client #5]..."
-06/06/23 at 7:59pm No name identified-"[QP #2]...Caller ADV there is a combative resident."
-07/3/23 at 3:54pm-"[Former QP #3]...Caller advd that she is enroute to the facility at this time and she ADVD that she know that he will probably attack her too once she gets there...Caller advd that she received a call from a staff (unknown staff) member stating that [FC #10] is attacking them..."
-07/13/23 at 5:11pm No name identified-"ADV`D THEY ARE AT THE BACK BUILDING...Ref (reference) a juvenile at the facility attempting to run away..."
-07/16/23 at 8:15pm (no name identified)-"[FS #14]...Patient is being pinned down by employees at this time, he busted out on of the glass doors in the facility."
-07/25/23 at 12:46am-"...Caller ADVD [Client #5] busted out the door and is now at the top of the road..."
-08/05/23 at 5:11pm-"...Child back in custody of clinic...Caller advd [Client #1] has ran away from the clinic...Made a right into town..."

During interview on 08/24/23 client #1 revealed:
-He "busted" out the door.
-The "dead bolt" was not locked.

During interview on 08/24/23 client #5 revealed:
-The staff called the police every time he "acted

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out."
-He had been in and out of the facility because the staff kept calling the police.

During interview on 09/05/23 the Residential Director/Crisis Prevention Institute Instructor revealed:
-She did not know anything about the ant poison.
-She did not have any reports reflecting screws, shampoo and ant poison pertaining to client #5.
-"None of that" was reported to her.

During interview on 08/29/23 staff #5 revealed:
-FC #10, client #1 and client #5 busted the door because they "wanted attention."
-The staff call 911 and they are "not supposed to chase after them."
-The clients do not get far.
-The clients would go to the top of the hill and the police would be waiting for them.
-It had happened like 4 times since he had worked at the facility.
-The police had come to the facility for clients running away.

Finding #5
Below is how the facility failed to coordinate with other individuals and agencies within the child or adolescent's system of care.

Review on 08/29/23 of client #3's record revealed:
-12 year old male.
-Admitted on 05/2/23.
-Diagnoses of Conduct Disorder, Attention Deficit Hyperactivity Disorder combined and Disruptive Mood Dysregulation Disorder.

Review on 08/29/23 of a Physician note for client #3 dated 06/13/23 revealed:

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V 301	Continued From page 35 -"Needs glasses Rx (Prescription)" Review on 08/29/23 of a primary care visit for client #3 dated 06/27/23 revealed: -"Routine physical examination...Failed eye screening..." Interview on 08/30/23 client #3 stated: -He was supposed to wear glasses. -He went to the eye doctor almost 2 months ago. -He "really needs them." -The doctor said his left eye was not fully developed. Interview on 09/01/23 client #3's legal guardian representative stated: -Client #3 was taken for an eye exam and he had a prescription for glasses. -It was discussed during a child and family team meeting with the facility on 07/06/23 that the glasses were not back. -She was unsure of the date of the eye exam. -Client #3 was supposed to receive his glasses the week after 07/06/23. Interview on 09/07/23 the House Manager stated: -Client #3 had an eye appointment scheduled. -He normally transported clients to their medical appointments. -He had not transported client #3 to an eye doctor appointment. Interview on 09/07/23 the lead Qualified Professional stated: -She had not seen any documentation client #3 was seen by an eye doctor. Interview on 09/07/23 the Nurse stated: -Glasses were taking about 8 weeks due to insurance.	V 301		

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-The facility had a lot of "turn over and information gets lost in translation."
-A former QP was in charge when client #3 went to the eye doctor and received his prescription.
-Client #3 was seen at a local eye doctor on 06/13/23.
-The former lead QP was supposed to order the glasses.
-She was unsure if client #3's glasses were ordered.
-She would follow up with eye doctor about client #3's glasses.

Interview on 08/25/23 the Residential Director/Crisis Prevention Institute Instructor stated:
-The nurse and house manager were responsible for scheduling client appointments.

Review on 09/07/23 of the Plan of Protection dated 09/07/23 and completed by the Lead QP revealed:
"-What immediate action will the facility take to ensure the safety of the consumers in your care?
QP will train staff on how to follow policy/procedures. The facility will ensure all intensive clients are provided with structural environment. Intensive clients are provided with structural treatment/supervision. The facility will complete admission assessments to ensure all clients needs can be met.
Describe your plans to make sure the above happens.
The facility will make sure we are meeting the clients needs by team discussing current behaviors strengths or weaknesses. The therapist will make sure that all strategies are for the clients current behaviors."

The facility served clients aged 10-17 years old

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V 301	Continued From page 37 with diagnoses to include Adjustment Disorder, ODD, ADHD, DMDD, and Intellectual Developmental Disabilities. The facility incident reports for the months of April-August 2023 revealed predominately aggressive and harmful behaviors of clients attacking other clients and clients attacking staff in the facility and elopement. Client #5 had ingested toothpaste/shampoo/shower/gel and a later room search revealed a sock of screws. Client #5 had been discharged from the hospital back to the facility after he ingested fire ant poision had verbalized self harm and went outside and ingested ant poision. The facility had no processes in place to prevent future occurrences for safety and supervision. The facility was repeatedly utilizing the police department to assist the facility to ensure clients were maintained in a safe environment from harmful and destructive behaviors The facility had not coordinated with client #3's eye doctor to ensure that he received his glasses and he had failed an eye screening and needed his glasses to see. The facility had no system in place to ensure care coordination of clients needs were met. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $3,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for failure to correct within 23 days.	V 301		
V 302	27G .1802 Intensive Res. Tx. Child/Adol - Req. of L P 10A NCAC 27G .1802 REQUIREMENTS OF LICENSED PROFESSIONALS (a) Each facility shall have at least one full-time	V 302		

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licensed professional. For purposes of this Rule, licensed professional means an individual who holds a license or provisional license issued by the governing board regulating a human service profession in the State of North Carolina. For substance related disorders this shall include a Licensed Clinical Addiction Specialist or a Certified Clinical Supervisor.
(b) The governing body responsible for each facility shall develop and implement written policies that specify the clinical and administrative responsibilities of its licensed professional(s). At a minimum these policies shall include:
(1) supervision of direct care staff;
(2) oversight of emergencies;
(3) provision of direct clinical psychoeducational services to children, adolescents or families;
(4) participation in treatment planning meetings; and
(5) coordination of each child or adolescent's treatment plan.

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to have at least one full time Licensed Professional (LP) providing the required clinical and administrative duties related to client services. The findings are:

Review on 09/07/23 of the LP's record revealed:
-Hire date 03/23/23.
-Last day of employment was 06/08/23.

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V 302	Continued From page 39 During interview on 08/24/23 client #1 revealed: -He had not seen a therapist since he had been at the facility (06/16/23). During interview on 08/30/23 client #3 revealed: -He had not seen a therapist in "a while." During interview on 08/30/23 client #2 revealed: -It had been 3 months since he had seen a therapist. -The last therapist quit. During interview on 08/30/23 client #8 revealed: -He had not seen a therapist at the facility. (Admission date 08/07/23) Interview on 08/25/23 the Residential Director/ Crisis Prevention Institute Instructor stated: -There was no current LP at the facility. -The previous LP "abruptly quit" approximately 1 month ago. -The agency was actively recruiting for a LP. During interview on 09/07/23 the Human Resources Director revealed: -The LP "quit." -He did not give any reason or explanation for quitting.	V 302		
V 304	27G .1804 Intensive Res. Tx. Child/Adol - Min staffing 10A NCAC 27G .1804 MINIMUM STAFFING REQUIREMENTS (a) A Qualified Professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) If children or adolescents are cared for in	V 304		

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separate units/buildings, the minimum staffing numbers shall apply to each unit/building.
(c) The minimum number of direct care staff required when children or adolescents are present and awake is as follows:
(1) three direct care staff shall be present for up to six children or adolescents;
(2) four direct care staff shall be present for seven, eight or nine children or adolescents; and
(3) five direct care staff shall be present for 10, 11 or 12 children or adolescents.
(d) During child or adolescent sleep hours three direct care staff shall be present of which two shall be awake and the third may be asleep.
(e) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(d) of this Rule, more direct care staff may be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan.

This Rule is not met as evidenced by:
Based on record reviews, observation and interviews the facility failed to meet the minimum staffing requirements. The findings are:

Finding #1: 3 staff were required with 4 or 5 clients.

Review on 09/01/23 of Former Client (FC) #10's record revealed:
-16 year old male.

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-Admission date of 06/12/23.
-Discharge date of 07/03/23.
-Diagnoses of Disruptive Mood Dysregulation Disorder, Mild Intellectual Disability, Attention Deficit Hyperactivity Disorder and Conduct Disorder

Review on 08/25/23 of a North Carolina Incident Response Improvement System (IRIS) report for FC #10 revealed:
-Date of incident: 07/03/23.
-Time of incident: Unknown.
-"Describe the cause of this incident, (the details of what led to this incident). On July 2, 2023, [FC #10] was still up but at first was not really doing when 2nd shift was still on shift. Once 2nd shift left, he started to get very hyper. He came into the bathroom while staff was cleaning the bathroom. He took the spray bottle and poured into the toilet. Staff redirected him and asked him why did he pour the chemical in the toilet, he stated f**k you b***h. Staff (unknown staff) redirected him to calm down and that was inappropriate. Then he grabbed the fire extinguisher and sprayed every body in the facility causing to wake up the clients (unknown clients) that was sleep. Staff (unknown staff) redirected him several times put the fire extinguisher down. He refused. Staff (unknown staff) reached to try to get the fire extinguisher from him but he spitted in staff (unknown staff) face and started to punching and kicking staff (unknown staff). He then ran out the facility by busting the doors open threatening to bust the staff (unknown staff) windows out. Then he jumped on the staff (unknown staff) car and jumping on the car. He then went back inside the building. When staff (unknown staff) went into the kitchen to call the police, he then went into a rage and began to bust the doors down because staff was in the

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V 304	Continued From page 42 kitchen. Staff (unknown staff) stated he was trying to get any one he could that was in the building. Staff (unknown staff) felt like her life and clients life was in jeopardy. Police arrived to the facility and was able to de-escalate the situation. He return back into the facility calm. [FC #10] received his PRN (as needed) and was calm for 2 hours then around 3 am he began to become aggressive towards staff (unknown staff) again. While staff (unknown staff) was cleaning up, he picked up the bottle and started spraying clients (unknown clients) and staff with bleach. Staff (unknown staff) was able to get the bottle from him. He then busted out the facility and started throwing rocks at staff (unknown staff) and there cars. Police was called. The police called the ambulance and was transported to hospital to get further evaluated. QP (Qualified Professional) (unknown QP) called the on call DSS (Department of Social Services) worker. To report the incident. The on-call DSS work returned my called and was informed about the incident and then DSS worker stated she will inform her supervisor. The supervisor called. QP (unknown QP) did let her know about the incident and that he will be discharged from our facility due to health and safety of our clients. The supervisor stated that someone will be calling the QP in a few hours once his DSS worker comes into the office. QP (unknown QP) called the DSS worker to make sure they are aware of the situation. The DSS did not pick up the phone but QP (unknown QP) left a message. About hour later, QP (unknown QP) received a phone called from the supervisor. He was informed about the incident. A verbal emergency discharged was give due to the health and safety of the clients and the assaults' towards staff (unknown staff) and peers (unknown clients). QP (unknown QP) did follow up with written discharged summary on 7/5/2023.	V 304		

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-Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. Just make sure all chemicals are put away while clients are up. Also, give PRN when staff see when the client is becoming agitated and frustrated and use CPI (Crisis Prevention Institute) Interventions."
-Local police department notified.
-Completed by Former Lead QP.

Review on 08/30/23 of local police department "Incident/Investigation Report (s)"
07/02/23 at 11:15pm
-Incident Simple Assault.
-Victim #1 was client #2 and Victim #2 was Former Staff (FS) #18.
-Witness staff #8.
-Narrative: "On July 2, 2023, at approximately 2327 (11:27pm) I, [local police name], responded to 703 W 3rd Ave, Building B due to a report of an assaultive resident at the facility. Upon arrival, the door was opened by worker Ms. [FS #18] ([Date of Birth] FS #18 birth date). The air was full of particulate of that which is emitted from a fire extinguisher. Ms. [FS #18] informed me that [FC #10] was acting aggressive again tonight (there was a call for service for the same juvenile last night). That [FC #10] had spit on her and taken the fire extinguisher off the wall and sprayed another juvenile resident, [Client #2] with the same. At about the same time [FC #10] came up on my left side covered in fire extinguisher particulate and informed me that he had sprayed the fire extinguisher because he was mad and the others were getting on his nerves. At that point another worker, a Ms. [Staff #8], came up and said something regarding [FC #10's] behavior. [FC #10] then got in Ms. [Staff #8's] physical

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space and began to act like he was going to bow up on her and assualt her. I, [local police officer] then commanded [FC #10] to step back to the other side of the hallway, which he did. At that point. [2nd local police officer] arrived and began speaking with [FC #10] while I gathered other information from Ms. [Staff #8] ([date of birth]) and Ms. [FS #18]. Due to this being a group home and [FC #10] guardian being [county] county DSS (Social Worker is [Guardian]), I informed Ms. [Staff #8] that our only resource is to take out juvenile petition and if the aggressive behavior continued, that he may have to be IVC's (involuntary committed)..."

07/03/23 at 3:14am
- Simple Assault.
- Victim #1 was Staff #8, Victim #2 was Client #2 and Victim #3 was FS #18.
- "On Monday, July 3, 2023, at approximately 0314 (3:14am), I, [local police officer], and [2nd local police officer] responded to 703 W. 3rd Ave. Building B, for the second time that shift. Upon arrival, I was again met by [Staff #8] and [FS #18]. Ms. [Staff #8] was coming out of the main door stating, that [FC #10] had sprayed bleach in her eyes, therefore, I immediately called for EMS to come to the facility and instructed her to rinse her eyes with water and remove her false eyelashes in the mean time. [FS #18] also informed me that [FC #10] had spayed her head with bleach and sprayed [Client #2] as well. I asked how [FC #10] came to be in possession of the chemical and Ms. [FS #18] stated they had been cleaning up the mess from earlier incident with the fire extinguisher having been deployed. [FC #10] was still angry at the two staff members earlier and was angry that they had called the police. He took the bottle of cleaner from Ms. [Staff #8] and started spraying them. Ms. [Staff

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#8] commented that [FC #10] had taken her keys and thrown them in the toilet. Ms [FS #18] commented that he had broken the security key as well. After flushing her eyes and being checked out by the medic, Ms [Staff #8] attempted to use her key fob and found it no longer functional."

07/03/23 at 3:54am
- Simple Assault.
- Victim #1 was FS #18 and Victim #2 was Staff #8
- On Monday, July 3, 2023, at approximately 0354 (3:54am), I, [local police officer], and [2nd local police officer], responded to 703 W. 3rd Ave (Building B) for the third time in four hours. For this incident communications informed us that [FC #10] was physically attacking staff. When I arrived, [Staff #8] was walking down the driveway from the building to 3rd Ave. As I pulled up to the building, the doors which were normally secured were wide open. As I exited my vehicle, Ms. [FS #18] ran up to me to tell me that [FC #10] had run behind the building after physically attacking them. As I made my way behind the building, I radioed to [2nd local police officer] that [FC #10] had gone into the wood line. i called [FC #10's] name. He answered me and I commanded him to return to the building and he did so. I then handcuffed him behind his back and put him into the back of my patrol car. After putting [FC #10] in my patrol car, [Staff #8], who had returned up the driveway, handed her phone to speak with [Former QP #3], Qualified Professional, at that organization. Ms. [Former QP #3] expressed her frustration over [FC #10's] behavior and requested charges be filed. I assured her that they would be however, because [FC #10] is a juvenile and so far his actions that evening had been misdemeanors, that law enforcement, could

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not take him into custody. I told her that I recommended that he be taken to the hospital for commitment purposes, whether voluntary or involuntary....After speaking with [Former QP #3], I got further information from Ms. [FS #18] and Staff #8]. Ms. [FS #18] informed me that [FC #10] had attacked [FS #18] by punching her in the face and kicking her. She informed me that [FC #10] had picked up the same fire extinguisher that he had used before and gone after Ms. [Staff #8] as if he would hit her with it. Ms. [FS #18] stated that [FC #10] managed to break through the locked inner security door because he ran at it with such force..."

Interview on 08/31/23 staff #8 stated:
-She had worked at the facility since March 2023.
-She normally worked 3rd shift from 11pm to 7am.
-She recalled the incident on 07/02/23 and 07/03/23 with FC #10.
-She and FS #18 were the staff on shift.
-There would normally be 3 staff on the schedule but only she and FS #18 were there.
-FC #10 was saying he was hungry and was acting up.
-She was unsure how FC #10 got the fire extinguisher, but he sprayed it.
-She called the police and another staff came from the sister facility for a few hours and then left after FC #10 calmed down.
-FC #10 got agitated and would not let anyone sleep and called people names.
-FC #10 took the spray bottle while she was cleaning and sprayed her and FS #18 in the eyes.
-The police were called a 2nd time.
-The ambulance came and the police talked to FC #10.
-The police left and FC #10 started grabbing my hat.

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-FC #10 grabbed my keys and flushed them in the toilet.
-She called the police again and FC #10 "threatened if police called he would act a fool."
-The police took FC #10 on the 3rd call and staff contacted QP #3.
-It was probably "2:30 (am) or 2:45 (am)" during the incidents.
-There were probably 4 or 5 clients at the facility with 2 staff.
-There are 3 staff working at night now.
- She did not know who "called out" to make it short staff on 07/02/23 and 07/03/23.
- "Sometimes people call out."

Attempt to interview FS #18 on 08/31/23 was unsuccessful after incorrect phone number was on file and no other phone number was available for FS #18.

Attempt to interview Former QP #3 on 09/05/23 was unsuccessful after message was left requesting a return call and no return call was received.

Finding #2: 4 staff were required with 7 clients.

Review on 08/24/23 of client #1's record revealed:
-15 year old male.
-Admission date of 06/16/23.
-Diagnoses of Adjustment Disorder, with mixed disturbance of emotions and conduct, Oppositional Defiant Disorder and Intellectual Developmental Disability, Mild.

Review on 08/24/23 of client #5's record revealed:
-13 year old male.

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-Admission date 05/06/23.
-Diagnoses of Disruptive Mood Dysregulation Disorder, Conduct Disorder, childhood onset type, Intellectual Developmental Disability, Mild, Child Physical Abuse, Child Psychological Abuse and Child Neglect.

Review on 08/31/23 of an IRIS report for client #1 revealed:
-Date and time of the incident: 08/22/23 at 3:00pm.
-"Describe the cause of this incident, (the details of what led to this incident). [Client #1] started acting out because the other consumers (unknown clients) were acting out and [Client #1] kicked the back door open which is a steel door and he was running up and down the hallways threatening staff (unknown staff) and threatening police officers."
-"Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. [Client #1] needs to be removed from the area where the behaviors are occurring due to the fact [Client #1] will feed off of the negativity and behaviors from others."
-Completed by the Lead QP.

Review on 08/31/23 of an IRIS report for client #5 revealed:
-Date and time of the incident: 08/22/23 at 2:00pm.
-"Describe the cause of this incident, (the details of what led to this incident). Consumer [Client #5] was sent to room for his behaviors and he did not want to go so he started screaming and cursing at the consumers and the staff. He was using very fowl words and threatening staff (unknown staff) and the other consumers (unknown clients).

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He threatened a police officer as well."
-"Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. The incident could have been prevented if the staff (unknown staff) would have stepped back and let the officers do their job. The staff needs to stop arguing with the consumers and screaming at them to stop something. In service training will be provided by the corporate office again and also in the facility to be sure that the staff understand not to raise their voices when the consumer has already been triggered into a behavior."
-Completed by the Lead QP.

Review on 08/24/23 of client #1's hospital summary dated 08/22/23 revealed:
-"Reason for visit: Behavior Problem"

Review on 08/24/23 of client #5's hospital summary dated 08/22/23 revealed:
-"Reason for visit: Behavior Problem"

Interview on 08/29/23 client #1 revealed:
-Staff #2 sent us to our room for no reason.
-Staff #2 was "fussing" with him in front of the police.
-She told the police he was lying when he was talking to the police.

Interview on 08/24/23 client #5 revealed:
-He was "in behavior" because the staff sent them to their rooms for no reason.
-They were just being loud.
-The police came to the facility.
-The police had to get all of them under control.
-The staff were arguing with the clients.
-The police told the staff to stop arguing with the

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clients.
-"Sometimes 2 or 3 staff. That is the most."

Interview on 08/30/23 client #2 revealed:
-The police came.
-Everyone except him was acting out.
-The clients were running, breaking things, hitting things and screaming.
-A staff was called from the sister facility (in front of the facility) to help.
-3 or 4 staff (on shift).

Interview on 08/30/23 client #3 revealed:
-Clients #1, #5 and #8 were having a behavior (08/22/23).
-Client #8 was mad at QP #1.
-They were trying to bust down the door (08/22/23).
-The staff made us go to our room.
-3 staff were working.
-The police were able to get every one calm.
-3 staff "normally" work at the facility.

Interview on 09/01/23 client #6 revealed:
-He had not been at the facility long.
-3 staff worked at the facility.

Interview on 08/30/23 client #8 revealed:
-Client #5 started acting out and client #1 started acting out (08/22/23).
-Client #1 started hitting client #5.
-He started acting out.
-The police came to the facility and client #1 and #5 had to go to the hospital.

Interview on 08/29/23 client #9 revealed:
-Clients #1, #5 and #8 were having a behavior.
-QP #1, QP #2 and FS #13 were the staff at the facility.

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Interview on 08/29/23 FS #13 stated:
-She worked at the facility for 2 months.
-There would be 2 staff on shift.
-Other staff assigned to the shift would come for "30 minutes to hour and leave."
-Staff would stay outside or go to the sister facilty.
-The House Manager and QP were included in staffing but "they were never there."
-There were "several times" when there was only 2 staff and 5 to 9 clients.
-There were "many times" they needed "more staff" when several incidents occurred.

Interview on 08/25/23 staff #2 stated:
-She worked at the facility for 3 weeks.
-She worked 1st shift but would stay until 8pm if there were no 2nd shift staff.
-There were 3 staff for 1st shift.
-She had "never" worked with 4 staff.
-On 8/22/23 there were 7 clients present.

Interview on 08/25/23 a local police detective stated:
-She was at the facility on 08/22/23.
-Several police officers had gone to the facility and we had to "restore order" at the facility.

Interview on 08/24/23 the Lead QP revealed:
-She had worked at the facility for 2 weeks.
-She had gone to the main office for a meeting on 08/22/23.
-She had gotten a phone call from QP #1 stating client #5 was "acting out."
-When she arrived at the facility several police officers and fire and rescue were at the facility.
-Client #5 was already on the ambulance and he was threatening to kill other consumers.
-Staff #2 was arguing with the clients.
-Staff #2 was calling client #1 a liar.
-FS #13 and staff #2 were in the facility.

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-The QP #1 had gone on break.
-When the crisis occurred FS #13 walked out of the facility and left staff #2 by herself in the facility.
-"That could have put that young lady (staff #2) in a lot of damage."
-"Should be 4 (staff) on first shift and 4 (staff) on second shift."
-"With the 9 clients they had now they did not have enough staff to meet the needs of the clients."

Finding #3: 3 staff were required with 4 clients.

Review on 08/24/23 of client #1's record revealed:
-15 year old male.
-Admission date of 06/16/23.
-Diagnoses of Adjustment Disorder, with mixed disturbance of emotions and conduct, Oppositional Defiant Disorder and Mild Intellectual Developmental Disability.

Review on 08/24/23 of an incomplete level I facility incident report for client #1 revealed:
-Date and time of incident: 08/05/23 at 5:10pm.
-"At around 5:10pm, I (QP #2) heard a loud bang at the door. Ms. [Staff #16] comes to my door to inform me that [Client #1] has broken out of the building. I walk down the road to see that [Client #1] has made a right of the campus. Mr. [Staff #10] calls the police. I am on the phone with the police explaining what has happened and where he went off campus. 5 mins (minutes) later, [Staff from sister facility] brings [Client #10] back after I got off the phone with [Former Lead QP]. I called [Former Lead QP] after I got off the phone with police. At around 5:30pm, [Client #1] was back in his room and he was placed in a CPI hold due to

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punching and kicking staff and having verbal threats towards staff..."
-Signed by QP #2.

Review on 08/28/23 of facility surveillance video dated 08/5/23 revealed:
-The video did not offer audio.
-Staff #10 and staff #16 were the only direct care staff present at the facility.
-QP #2 was in the locked office. (Staff #10 knocked on the locked office door but the QP #2 did not respond)
-At 5:06 pm, client #1 was tampering with the back door as staff #10 appeared to verbally redirect client #1.
-5:07pm, client #1 paced the facility as he went into another client's bedroom and staff #10 followed and appeared to hold client #1's arms by his side as they came back into the hallway. Client #1 fell to the floor and was released by staff #10.
-Staff #10 and Staff #16 were both on the hall and attempted to verbally engage client #1 before he ran past staff #10 and staff #16 towards the front door and exited the facility.
-Staff #10 ran to the front door.
-Staff #10 again knocked on the office door and QP #2 exited the office and went outside.
-Staff #10, staff #16 and QP #2 were all outside of the facility leaving the 4 clients present alone for approximately 1 minute.
-5:16 pm, staff #11 had client #1's arms wrapped in a restraint as he walked him back to the facility as QP #2 stood outside.
-5:18 pm, local police arrived and turned around in the yard of the facility. Local police did not engage anyone.

Interview on 08/28/23 staff #10 stated:
-He worked as needed as direct care staff.

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-He only worked when no other staff were available.
-He had worked shifts with just him and another staff.
-He was present when client #1 eloped on 7/20/23.
-There was one staff and the QP present but he was unsure of their names.
-The QP called the police but client #1 was back at the facility when they responded.

Interview on 08/28/23 the Residential Director/Crisis Prevention Institute Instructor stated:
-On 08/5/23, there were 3 staff (staff #5, staff #6 and staff #9) and QP #2 were scheduled to work.
-She was unsure why none of the staff scheduled to work were not at the facility.
-Staff #10 was the maintenance worker and worked as direct care as needed.
-Staff #16 worked at the sister facility and filled in at this facility.
-She believed there were 5 clients present at the time.

Finding #4: Four staff were required with 7 clients.

Observation on 09/01/23 at approximately 10:30am revealed:
-7 clients were present in the facility.
-3 staff were present in the facility.

During interview on 09/01/23 the Facility Manager revealed:
-Three staff were present today (09/01/23).
-A staff called out.
-"We only have 7 clients today because [Client #1] was IVC'ed (Involuntary Committed) due to

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attacking [Client #6]."

Interview on 08/29/23 the QP #2 stated:
-She had worked at the facility since June 2023.
-She was the QP for 2nd shift.
-The staff had increased as client numbers increased.

Attempt to interview Former QP #3 on 09/05/23 was unsuccessful after message was left requesting a return call and no return call was received.

Review on 08/25/23 of a Plan of Protection signed by the Lead QP and dated 08/25/23 revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care? The facility will ensure that the minimum requirement of staff will be available to cover all shifts. For the structural environment for intensive treatment of our consumers.
-Describe your plans to make sure the above happens. Lead QP and Facility Manager will at all times be sure the schedule on all shifts are staffed and that staff will be contacted prior to their shifts for confirmation."

Clients ages range from 12 to 16 years old. Diagnoses include Adjustment Disorder, with mixed disturbance of emotions and conduct, Oppositional Defiant Disorder, Disruptive Mood Dysregulation Disorder, Mild Intellectual Disability, Attention Deficit Hyperactivity Disorder, and Conduct Disorder. On 07/2/23 and 07/3/23 FC #10 had multiple aggressive behaviors and eloped from the facility. There were 2 staff on shift and the police had to be called a total of 3 times to redirect FC #10's behavior and bring safety and order to the facility. FC #10 sprayed

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V 304	Continued From page 56 the fire extinguisher and emergency medical services was contacted due to the concern with chemicals and threatened to attack staff with the fire extinguisher as well as sprayed cleaning chemicals in staff's eyes. On 07/20/23, client #1 eloped from the facility. There were only 2 direct care staff present with 5 clients present and there should have been 3 direct care staff present. On 08/22/23 there should have been 4 staff at the facility during the shift. A staff left the facility during the outbreak of behaviors and a staff was on break which left one staff to meet the needs of 9 clients. The behaviors of the clients required law enforcement, emergency medical services and the fire department's involvement to assist with the clients' behaviors resulting in client #1 and client #5 having to go to the hospital. The lack of required minimum staff to meet the clients needs was a factor in 2 incidents. The facility did not provide the minimum staff required to implement treatment strategies to address client behaviors to keep clients safe and often defaulted to calls to the police to intervene with the clients to bring safety and order to clients at the facility. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $3,000.00 is imposed. if he violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for failure to correct within 23 days.	V 304		
V 305	27G .1805 Intensive Res. Tx. Child/ Adol - Operations 10A NCAC 27G .1805 OPERATIONS (a) Each facility shall serve no more than 12 children or adolescents. (b) Family members or other legally responsible	V 305		

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persons shall be involved in development of plans in order to assure a smooth transition to a less restrictive setting.
(c) Educational services within the facility shall be arranged and designed to maintain the educational and intellectual development of the child or adolescent. Treatment staff shall coordinate with the local education agency to ensure that the child or adolescent's educational needs are met as identified in the education plan.
(d) Psychiatric consultation shall be available as needed for each child or adolescent.
(e) If an adolescent has his 18th birthday while receiving treatment in the facility, he may remain for six months or until the end of the state fiscal year, whichever is longer.
(f) Each child or adolescent shall be entitled to age-appropriate personal belongings unless such entitlement is counter-indicated in the treatment plan.
(g) Each facility shall operate 24 hours per day, seven days per week, and each day of the year.

This Rule is not met as evidenced by:
Based on interviews and record reviews and observations, the facility failed to ensure the educational services were made available to meet the clients' needs for 7 of 7 audited clients (#1, #2, #3, #5, #6, #8 and #9). The findings are:

Review on 09/6/23 of a 2022-2023 School Year Roster for the facility's school revealed:
-Current as of 04/24/23.
-Client #1, client #2, client #3, client #5 and client #8 were not listed.

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Review on 08/24/23 of client #1's record revealed:
-15 year old male.
-Admission date of 06/16/23.
-Diagnoses of Adjustment Disorder, with mixed disturbance of emotions and conduct, Oppositional Defiant Disorder (ODD) and Mild Intellectual Developmental Disability (IDD).
-No information on educational needs.

Review on 08/24/23 of client #2's record revealed:
-13 year old male.
-Admitted on 05/04/23.
-Diagnoses of ODD and Bipolar Unspecified.
-No information on educational needs.

Review on 08/29/23 of client #3's record revealed:
-12 year old male.
-Admitted on 05/02/23.
-Diagnoses of Conduct Disorder, Attention Deficit Hyperactivity Disorder (ADHD) combined and Disruptive Mood Dysregulation Disorder (DMDD).
-No information on educational needs.

Review on 08/24/23 of client #5's record revealed:
-13 year old male.
-Admitted on 5/6/23.
-Diagnoses of DMDD, Conduct Disorder, childhood onset type, Intellectual Developmental Disability (IDD), Mild, Child Physical Abuse, Child Psychological Abuse and Child Neglect.
-No information on educational needs.

Review on 09/01/23 of client #6's record revealed:
-10 year old male.

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-Admission date of 08/17/23.
-Diagnoses of ADHD and DMDD.
-No information on educational needs.

Review on 08/24/23 of client #8's record revealed:
-10 year old male.
-Admitted on 08/07/23.
-Diagnoses of Reactive Attachment Disorder of Childhood, ADHD combined type, Enuresis, Conduct Disorder, Posttraumatic Stress Disorder and ODD.
-No information on educational needs.

Review on 0/24/23 of client #9's record revealed:
-10 year old male.
-Admission date of 02/14/23.
-Diagnoses of Schizophrenia, Unspecified Type, ADHD, DMDD and ODD.
-No information on educational needs.

Interview on 08/29/23 client #1 revealed:
-They had a teacher.
-They did not see her.
-She had been out a long time.
-She comes to the facility to bring the computers.

Interview on 08/30/23 client #2 stated:
-They were supposed to do school for 2 hours but staff "lets them slide."
-Staff took their computer and made them complete paper assignments if they "are acting up and not doing what they are supposed to."
-Staff normally took their computers for the day.

Interview on 08/30/23 client #3 stated:
-The teacher had been out for "2 weeks or a month."
-The house manager said they were supposed to "do school until 2" but they were normally

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"finished around lunch or 1pm."

Interview on 09/01/23 client #6 revealed:
-He did not have a computer.
-He wanted a computer.

Interview on 08/30/23 client #8 stated:
-He had not met the teacher.
-Staff #3 was the teacher assistant.
-They completed their work on their chromebook.
-He was supposed to be in the 5th grade but was still in the 4th grade.
-"You had to do paper assignments if the computer was taken away from you."

Interview on 08/30/23 client #9 revealed:
-He had to do school every day until "2pm or 2:30pm."
-His computer was locked.
-He could not do school when his computer was locked.
-"All the school work is on the computer."

Interview on 08/30/23, 09/05/23 and 09/06/23 the Exceptional Children's Director (ECD) stated:
-She worked as the teacher for the facility.
-She was not notified when the facility began to admit clients and found out about 2 months after admissions.
-The staff and former lead QP did not agree with her curriculum and the clients' use of computers and believed clients should use paper assignments.
-The clients admitted to the facility were not enrolled in school because she had not received the documents required for enrollment to include immunizations, transcripts or individual education plans (IEP).
-She placed the clients in the grade based on their age until the documents were provided.

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-She had spoken with some of the guardians in an attempt to get the clients information needed to enroll them in school.
-She was virtual and not allowed to go into the facility after a disagreement with the former lead QP who assaulted her.
-She had been virtual for about a month but was unsure of the exact date.
-She needed to be in the building "due to the clients' academic needs and their inability to work independently."
-She was not able to do zoom meeting with the clients due to their behaviors and staff not being able to do it.
-She used live chat to communicate with clients in a group based on their grade level but had not done so with the current facility.
-None of the clients were on grade level and all clients were currently failing.
-The teacher assistant would help the clients in the afternoons.
-She learned from the teacher assistant about client #4 and client #6 being admitted to the facility.
-She was unsure when client #4 and client #6 was admitted. She provided computers to them on 09/05/23.
-She droppped the computers off to the clients every morning and picked them up every afternoon.
-Staff would take the clients computers because staff wanted the clients to "use pencil and paper."
-She was unsure how long staff would keep the client's computers.

Interview on 09/06/23 staff #3 stated:
-She was hired as the teacher assistant and as an as needed direct care staff.
-She mostly worked as direct care but "tried to incorporate school."

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-She asked the former lead QP for the IEPs and had not received them.
-The ECD also asked for the IEPs so they could better serve the clients.
-The clients are "off task and below grade level."

During interview on 08/29/23 the House Manager revealed:
-The clients had laptop computers for school.
-He did not have any instruction on what they were learning.
-3 months since the teacher had been in the building.
-Client #2 did not have a computer because he played games on the computer instead of doing work.

Interview on 08/29/23 the Lead Qualified Professional (QP) stated:
-If the clients did not want to do school work, staff "can't make them"
-The teacher was not allowed in the building due to a previous incident with a client.
-The teacher assistant worked from 4pm - 10pm.

During interview on 09/05/23 the Residential Director/Crisis Prevention Institute Instructor revealed:
-The clients did not have IEPs.
-The teacher would be responsible for the IEPs.
-The teacher does not go into the building to do the education.
-The Licensee removed her from the building and she does the education remotely.
-She was removed because of how she interacted with staff.
-The teacher is responsible for distributing the computers to the clients.

Interview on 09/07/23 the Licensee stated:

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-The ECD worked virtually.
-There was a disagreement between the ECD and Staff.
-He made the decision to have the teacher work virtually to solve the problem.
-He was not aware of any issues with enrolling clients in school.
-The facility was in transition since the former lead QP left.

Review on 09/07/23 of the Plan of Protection dated 09/07/23 and completed by the Lead QP revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care?
The facility will ensure that the educational services within the facilities shall be arranged/designed to maintain the educational/intellectual development of the child/adolescent. Educational treatment staff shall coordinate with local education agencies to ensure that the clients needs are being met.
Describe your plans to make sure the above happens.
When the QP receives educational information prior to admission QP will submit to the teacher immediately."

The facility was licensed to provide intensive residential treatment for children and served clients with diagnoses to include Adjustment Disorder, ODD, ADHD, DMDD and Intellectual Developmental Disabilities. The clients ages ranged from 10 - 17 years old. The facility did not have educational information to include transcripts and IEPs to enroll 7 of the 9 current clients into school and serve clients based on their needs. The facility had not communicated with the ECD who was responsible for educational needs of the clients. The facility did

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V 305	Continued From page 64 not meet the academic needs of the clients when the Licensee made the decision to have the teacher work virtually to solve interaction problems between staff and the teacher and not provide any form of communication between the facility staff, clients and the ECD. The clients were to complete school work on their computers. However, some clients did not have a computer or computers were taken away for discipline purposes. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 305		
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	V 366		

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set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and
(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.
(b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.
(c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by:
(1) immediately securing the client record by:
(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;

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(C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and
(D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and
(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.

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V 366	Continued From page 67 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement written policies governing their responses to level I incidents. The findings are: Finding #1: Review on 08/24/23 of client #1's record revealed: -15 year old male. -Admission date of 06/16/23. -Diagnoses of Adjustment Disorder, with mixed disturbance of emotions and conduct, Oppositional Defiant Disorder and Mild Intellectual Developmental Disability. Review on 09/07/23 of client #1's level I facility incident reports revealed the following with no description of how these types of incidents may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incidents. -07/31/23 at 9:30am-verbal and physical aggression and property destruction, 07/28/23 at 8:30pm-verbal and physical aggression, 07/25/23 at 7:30pm-verbal and physical aggression, 07/25/23 at 7:05pm-verbal and physical aggression and property destruction, 08/17/23 at 9:00am-verbal and physical aggression, 08/05/23 at 5:00pm-verbal and physical aggression and elopement. Finding #2: Review on 08/29/23 of client #3's record revealed: -12 year old male. -Admission date of 05/02/23.	V 366		

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-Conduct Disorder, Attention Deficit Hyperactivity Disorder combined and Disruptive Mood Dysregulation Disorder (DMDD).

Review on 09/07/23 of client #3's level I facility incident reports revealed the following with no description of how these types of incidents may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incidents.
-07/28/23 at 8:30pm-verbal and physical aggression, restricitve intervention and threats to self or others.

Finding #3:
Review on 08/24/23 of client #5's record revealed:
-13 year old male.
-Admitted on 5/6/23.
-Diagnoses of DMDD, Conduct Disorder, childhood onset type, Intellectual Developmental Disability, Mild, Child Physical Abuse, Child Psychological Abuse and Child Neglect.

Review on 09/07/23 of client #5's level I facility incident reports revealed the following with no description of how these types of incidents may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incidents.
-07/28/23 at 8:30pm-verbal and physical aggression, restricitve intervention and threats to self or others, 07/20/23 at 8:30pm-self abuse and verbal/physical agression, 07/25/23 at 12:30 (unknown)-elopement, 07/28/23 at 8:30pm, 06/12/23 at 8:50am-safety issues, search and seizure and security issues.

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V 366	Continued From page 69 Interview on 09/07/23 the Residential Director/Crisis Prevention Institute Instructor stated: -Facility incident reports should be completed. -Level I reports should contain corrective measures, along with developing and implementing measures to prevent similar incidents.	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	V 367		

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

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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 incident reports were submitted to the Local Management Entity (LME)/Managed Care Organization (MCO) within 72 hours as required. The findings are:

Review on 09/7/23 of the North Carolina Incident Response Improvement System (IRIS) for July 1, 2023 thru September 7, 2023 revealed no level III reports submitted by the facility.

Review on 08/24/23 of client #1's record revealed:
-15 year old male.
-Admission date of 06/16/23.
-Diagnoses of Adjustment Disorder, with mixed disturbance of emotions and conduct, Oppositional Defiant Disorder and Mild Intellectual Developmental Disability.

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Review on 08/24/23 of client #5's record revealed:
-13 year old male.
-Admitted on 05/6/23.
-Diagnoses of Disruptive Mood Dysregulation Disorder, Conduct Disorder, childhood onset type, Intellectual Developmental Disability (IDD), Mild, Child Physical Abuse, Child Psychological Abuse and Child Neglect.

Finding #1:
Review on 08/24/23 of an incomplete facility level I incident report for client #5 revealed:
-Date and time of incident: 07/20/23 at 8:30pm.
-Description of incident/Accident: "[Client #5] started to get aggressive towards 2 other clients. Putting his arms around their necks, stating he was going to kill them. We attempted to calm him down for about 10 min (minutes) but he just kept escalating to more aggressive behavior physically to the same 2 clients. Staff (unknown staff) decided to remove [Client #5] to his room to separate him from the other clients for their safety and his own. Myself and Ms [Staff #6] & Ms [QP #2] decided to drag client to his room for safer detaining but when we got to his room, he refused to go in and started being physically aggressive so at that point we detained him on the floor. I (FS #14) detained his right arm, [QP #2] detained left arm and Ms [Staff #6] his feet. We tusselled w/ (with) [Client #5] for about 20 mins. He banged his head on floor & wall. He tried to punch and kick Ms [QP #2]. He accused ms [QP #2] of hurting his private part and sitting on his arm. I did not witness that."

Finding #2:
Review on 08/25/23 of a facility surveillance video dated 08/22/23 revealed:

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-The video did not offer audio.
-Approximately 1:59am, QP #1 left the facility.
-Staff #2 and FS #13 present with 6 clients.
-At 12:27pm, client #5 dragged client #8 by his feet out of his room. FS #13 stood still in the hallway with clients and watched. Once released by client #5, client #8 returned to his room. Client #5 had a face to face interaction with FS #12 before she directed him in the opposite direction and followed.
-12:29pm Client #5 went into client #8's bedroom and FS #13 went into client #8's bedroom and pushed client #5 about his body across the hall and into his (client #5) bedroom before client #5 ran out of his own bedroom while FS #13 was inside. Client #5 ran into the kitchen.
-12:32 - FS #13 gathered her food and drink and left the facility. FS #12 arrived from the sister facility.
-FS #12 removed client #5 from the kitchen and walked him to the hall. Client #5 fell to the ground and FS #12 picked client up under his arms with the client's back to the staff's and dragged client #5 into his bedroom.

Finding #3:
Review on 09/07/23 of a North Carolina IRIS Report for client #1 revealed:
-Date and time of the incident: 08/18/23 at 4:30pm.
-"Describe the cause of this incident, (the details of what led to this incident). [Client #1] was complaining about [Client #5]. [Client #1] was upset because he felt it was not fair that [Client #5]'s punishment was removed due to the fact that the previous day [Client #5] put [Client #1] in a chokehold. [Client #5] overheard [Client #1] saying these things and began arguing with him. [Client #5] initiates the fight by saying 'then do something.' [Client #1] grabs a broom, as the

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consumers are in the middle of doing chores. [Client #5] grabs the dustpan and hits [Client #1]. Both consumers release the objects and began fist fighting. Staff A (unknown staff) and Staff B (unknown staff) rush to break them apart. They were refusing to calm down so staff C (unknown staff) was called from the front building. [Client #1] was still refusing to calm down so staff C placed him in a CPI (Crisis Prevention Intervention) hold. He is eventually able to calm down."

Review on 08/23/23 of facility surveillance video dated 08/18/23 revealed:
-4:08pm client #1 quickly stood up and left from the common area table and staff #5 and staff #11 followed up.
-Client #1 went in the opposite direction of the hall where his bedroom was located.
-Staff #11 wrapped his arm around client #1 waist and picked him up off his feet and headed down the hall before they both fell to the floor.
-After getting off the floor briefly, staff #11 continued to struggle with client #1 before falling to the floor again.
-While client #1 was still on the ground, staff #11 stood up and grabbed of client #1's ankles and pulled him down the hall to his bedroom as staff #5 followed.
-Staff #5 stood at client #1's bedroom door while staff #11 went into client #1's bedroom.

Finding #4:
Review on 09/07/23 of an incomplete level I incident report for client #1 revealed:
-Date and time of incident: 08/05/23 at 5:10pm.
-Client #1 eloped from the facility and the police were contacted.
-No level II incident/IRIS report was documented in reference to law enforcement involvement at

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the facility.

Review on 09/07/23 of North Carolina IRIS reports revealed no level II incident report completed for client #1's behavior which involved law enforcement.

Interview on 09/05/23 the Residential Director/ Crisis Prevention Institute Instructor stated:
-The incidents with client #5 on 7/20/23, involving Former Staff (FS) #14 and FS #15, and on 8/22/23, involving FS #12 and FS #13 in which the client was dragged were considered to be abusive.
-The dragging incident with client #1 on 8/18/23 involving staff #5 and staff #11 was considered to be abusive.
-The facility should follow their policy and procedures for reporting abuse.

V 500 — 27D .0101(a-e) Client Rights - Policy on Rights — V 500

10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS
(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.
(b) The governing body shall develop and implement policy to assure that:
(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
(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

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neuroleptic medications.
(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:
(1) any restrictive intervention that is prohibited from use within the facility; and
(2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client.
(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:
(1) the permitted restrictive interventions or allowed restrictions;
(2) the individual responsible for informing the client; and
(3) the due process procedures for an involuntary client who refuses the use of restrictive interventions.
(e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes:
(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);
(2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and
(3) the establishment of a process for

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appeal for the resolution of any disagreement over the planned use of a restrictive intervention.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to report all instances of alleged or suspected abuse to the County Department of Social Services (DSS) for 4 of 13 audited current staff (Qualified Professional (QP) #2, staff #5, staff #6, staff #11) and 3 of 5 audited Former Staff (FS) (#12, #13, #14) as required. The findings are:

Review on 09/7/23 of the North Carolina Incident Response Improvement System (IRIS) for July 1, 2023 thru September 7, 2023 revealed no level III reports submitted by the facility.

Review on 09/7/23 of facility records revealed no documentation the local DSS was notified of allegations of abuse against staff #5, #6, #11 or the Qualified Professional (QP) #2 and former staff (FS) #12, #13 and #14.

Review on 08/24/23 of client #1's record revealed:
-15 year old male.
-Admission date of 06/16/23.
-Diagnoses of Adjustment Disorder, with mixed disturbance of emotions and conduct, Oppositional Defiant Disorder and Mild Intellectual Developmental Disability.

Review on 08/24/23 of client #5's record revealed:
-13 year old male.
-Admitted on 05/6/23.

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-Diagnoses of Disruptive Mood Dysregulation Disorder, Conduct Disorder, childhood onset type, Intellectual Developmental Disability (IDD), Mild, Child Physical Abuse, Child Psychological Abuse and Child Neglect.

Finding #1:
Review on 08/24/23 of an incomplete facility level I incident report for client #5 revealed:
-Date and time of incident: 07/20/23 at 8:30pm.
-Description of incident/Accident: "[Client #5] started to get aggressive towards 2 other clients. Putting his arms around their necks, stating he was going to kill them. We attempted to calm him down for about 10 min (minutes) but he just kept escalating to more aggressive behavior physically to the same 2 clients. Staff (unknown staff) decided to remove [Client #5] to his room to separate him from the other clients for their safety and his own. Myself and Ms [Staff #6] & Ms [QP #2] decided to drag client to his room for safer detaining but when we got to his room, he refused to go in and started being physically aggressive so at that point we detained him on the floor. I (FS #14) detained his right arm, [QP #2] detained left arm and Ms [Staff #6] his feet. We tusselled w/ (with) [Client #5] for about 20 mins. He banged his head on floor & wall. He tried to punch and kick Ms [QP #2]. He accused ms [QP #2] of hurting his private part and sitting on his arm. I did not witness that.

Finding #2:
Review on 08/25/23 of a facility surveillance video dated 08/22/23 revealed:
-The video did not offer audio.
-Approximately 1:59am, QP #1 left the facility.
-Staff #2 and FS #13 present with 6 clients.
-At 12:27pm, client #5 dragged client #8 by his feet out of his room. FS #13 stood still in the

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hallway with clients and watched. Once released by client #5, client #8 returned to his room. Client #5 had a face to face interaction with FS #12 before she directed him in the opposite direction and followed.
-12:29pm Client #5 went into client #8's bedroom and FS #13 went into client #8's bedroom and pushed client #5 about his body across the hall and into his (client #5) bedroom before client #5 ran out of his own bedroom while FS #13 was inside. Client #5 ran into the kitchen.
-12:32 - FS #13 gathered her food and drink and left the facility. FS #12 arrived from the sister facility.
-FS #12 removed client #5 from the kitchen and walked him to the hall. Client #5 fell to the ground and FS #12 picked client up under his arms with the client's back to the staff's and dragged client #5 into his bedroom.

Finding #3:
Review on 09/07/23 of a North Carolina IRIS Report for client #1 revealed:
-Date and time of the incident: 08/18/23 at 4:30pm.
-"Describe the cause of this incident, (the details of what led to this incident). [Client #1] was complaining about [Client #5]. [Client #1] was upset because he felt it was not fair that [Client #5]'s punishment was removed due to the fact that the previous day [Client #5] put [Client #1] in a chokehold. [Client #5] overheard [Client #1] saying these things and began arguing with him. [Client #5] initiates the fight by saying "then do something." [Client #1] grabs a broom, as the consumers are in the middle of doing chores. [Client #5] grabs the dustpan and hits [Client #1]. Both consumers release the objects and began fist fighting. Staff A (unknown staff) and Staff B (unknown staff) rush to break them apart. They

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were refusing to calm down so staff C (unknown staff) was called from the front building. [Client #1] was still refusing to calm down so staff C placed him in a CPI hold. He is eventually able to calm down."

Review on 08/23/23 of facility surveillance video dated 08/18/23 revealed:
-4:08pm client #1 quickly stood up and left from the common area table and staff #5 and staff #11 followed up.
-Client #1 went in the opposite direction of the hall where his bedroom was located.
-Staff #11 wrapped his arm around client #1 waist and picked him up off his feet and headed down the hall before they both fell to the floor.
-After getting off the floor briefly, staff #11 continued to struggle with client #1 before falling to the floor again.
-While client #1 was still on the ground, staff #11 stood up and grabbed of client #1's ankles and pulled him down the hall to his bedroom as staff #5 followed.
-Staff #5 stood at client #1's bedroom door while staff #11 went into client #1's bedroom.

Interview on 08/29/23 client #1 revealed:
-He had been dragged by his feet and arms by staff.
-QP #2 was the staff that had dragged him.
-She was pulling him by his legs and Staff #17 had him by his arms.
-Staff #17 was the maintenance person.

Interview on 09/05/23 the Residential Director/Crisis Prevention Insitute Instructor stated:
-The incidents with client #5 on 7/20/23, involving Former Staff (FS) #14 and FS #15, and on 8/22/23, involving FS #12 and FS #13 in which

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V 500	Continued From page 81 the client was dragged were considered to be abusive. -The dragging incident with client #1 on 8/18/23 involving staff #5 and staff #11 was considered to be abusive. -The facility should follow their policy and procedures for reporting abuse.	V 500		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (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. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by:	V 512		

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Based on record reviews and interviews 4 of 13 audited current staff (Qualified Professional (QP) #2, staff #5, staff #6, staff #11) and 4 of 5 audited Former Staff (FS) (#12, #13, #14, #15) abused 2 of 7 audited clients (#1 and #5) and 1 of 13 audited current staff (QP #2), failed to protect 1 of 7 audited clients (client #5) and 1 of 13 audited current staff (staff #5) failed to protect 1 of 7 audited clients (client #1) from abuse. The findings are:

Finding #1:
Review on 08/24/23 of client #5's record revealed:
-13 year old male.
-Admitted on 5/6/23.
-Diagnoses of Disruptive Mood Dysregulation Disorder, Conduct Disorder, childhood onset type, Intellectual Developmental Disability (IDD), Mild, Child Physical Abuse, Child Psychological Abuse and Child Neglect.

Review on 08/25/23 of FS #14's personnel record revealed:
-Date of hire: 07/05/23.
-07/05/23 General Orientation and Client Rights training.
-No seperation date noted.

Review on 08/25/23 of QP #2's personnel record revealed:
-Date of hire: 05/31/23.

Review on 08/24/23 of an incomplete facility level I incident report for client #5 revealed:
A.
-Date and time of incident: 07/20/23 at 8:30pm.
-Description of incident/Accident: "[Client #5] started to get aggressive towards 2 other clients. Putting his arms around their necks, stating he

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was going to kill them. We attempted to calm him down for about 10 min (minutes) but he just kept escalating to more aggressive behavior physically to the same 2 clients. Staff (unknown staff) decided to remove [Client #5] to his room to separate him from the other clients for their safety and his own. Myself and Ms [Staff #6] & Ms [QP #2] decided to drag client to his room for safer detaining but when we got to his room, he refused to go in and started being physically aggressive so at that point we detained him on the floor. I (FS #14) detained his right arm, [QP #2] detained left arm and Ms [Staff #6] his feet. We tusselled w/ (with) [Client #5] for about 20 mins (minutes). He banged his head on floor & wall. He tried to punch and kick Ms [QP #2]. He accused ms [QP #2] of hurting his private part and sitting on his arm. I did not witness that. My back was to them a majority of the time. When a male staff (unknown staff) arrived he refused to take his prn (as needed) and calm down. Later about an hour he calmed down."
-Incident report signed by FS #14.

B.
-Date and time of incident: 07/20/23 at 8:45pm.
-Narrative: "Consumer A ([Client #5]) continually kept using profanity by using the slang vagina which kids say (p***y). After being told by staff A ([FS #14]) and staff B ([Staff #6]) he then went to put consumer B ([Client #2]) in a chokehold. Staff A stopped him. He then went to put consumer C ([Client #1]) in a chokehold and staff B stopped him. He then went back to consumer B to attempt to put him in another chokehold. Staff A and Staff B then went to put consumer A in a restraint. Consumer A refused to go to his room, so staff A and B then continued to put him in a restraint where staff C ([QP #2]) then came along to aid. As staff A, B and C have consumer A in restraint,

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he's trying to punch staff C; so staff A, B, and C have all body parts of consumer A held down. All staff members are trying to calm Consumer A down, he finally calms down about twenty minutes later and agrees to sit in his room while sitting in his room he's still making threats of himself and staff. Consumer A about an hour later then apologizes to staff A, B, and C after talking to Staff B and agrees to take his PRN. Our shift is approaching an end as this is happening around 9:00pm till. This is all the information too report."
-Incident report was signed by staff #6 on 07/20/23.

C.
-Date and time of incident: 07/20/23 at 8:30pm.
-Narrative: "At around 8:30pm [Client #5] was going around putting other consumers into choke holds. [Staff #6] and [FS#14] first told [Client #5] to stop when he done the first time. He laughed and went to another consumer. That is when [Staff #6] and [FS #14] had to place [Client #5] into a hold to stop him from causing harm to other consumers. He became combative to my staff (unknown staff), and that is when I grabbed his arm so that he would not cause harm to my staff (unknown staff). We had [Client #5] in a CPI (Crisis Prevention Instutute) hold for about 30 mins (minutes). I (QP #2) called up front for a male staff (unknown staff) so that I could get [Client #5] a PRN (as needed). [Client #5] refused the PRN the first time. He made statements about causing harm to staff (unknown staff) and to himself..."
-Incident report signed by QP #2.

Review on 08/25/23 of the facility surveillance video dated 07/20/23 revealed:
-The video did not offer audio.
-Client #5 walked around the common area as

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V 512	Continued From page 85 the other clients sat and watched TV. -At approximately 8:46pm, client #5 wrapped his arms around client #1's neck as client #1 sat watching TV. -Staff identified as FS #15 intervened and attempted to remove client #5's arms from client #1's neck. -Client #5 released client #1 and FS #15 and FS #14 followed client #5. -FS #15 talked to FS #14 before holding both of his wrists. -FS #14 assisted FS #15 as they each held client #5's arms and walked him towards the hall before client #5 dropped to the floor. -Both FS #14 and FS #15 released client #5 and he ran around the common area table. -FS #14 followed client #5 as he ran around the common area then into the medication room as QP #2 exited. -QP #2 had not attempted to intervene as client #5 was in a behavior. QP #2 went into the office. -Client #5 continued to run around as FS #14 and FS #15 followed him. -At approximately 8:49pm, client #5 stopped beside the common area table as FS #14 and FS #15 grabbed his arms before he dropped to the ground. -FS #14 and FS #15 each grabbed one of client #5's arms as he was already on the floor then dragged him to his room as QP #2 followed at client #5's feet. -Once at client #5's bedroom door, FS #14, FS #15 and QP #2 held client #5 on the floor. -At approximately 9:18pm, staff #11 and staff #6 arrived from the sister facility as client #5 continued to be restrained by FS #14, FS #15 and QP #2 on the floor. -Staff #11 assisted FS #14, FS #15 and QP #2 with client #5	V 512		

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Interview on 08/31/23 FS #14 stated:
-She had worked at the facility for approximately 1 and 1/2 months.
-She usually worked 2nd shift - 3pm to 11pm.
-She had training in CPI.
-She recalled the 07/20/23 incident with client #5.
-Client #5 was in a behavior threatening to "snap" the necks of other clients and breaking light bulbs.
-They were trying to keep client #5 safe and the others safe.
-Staff had to "escort" client #5 to his room.
-We had to "detain" him.
-She, QP #2 and staff #6 were "holding" client #5.
-They held client #5 "about 30 minutes."
-Staff tried to get client #5 to go in his room but he would not go.
-"There was nothing about that position in CPI," we just tried to keep everyone safe.
-There were "no injuries" and she created an incident report.

Interview on 08/29/23 staff #6 stated:
-She had worked at the facility for approximately 2 or 3 months.
-She had training in CPI.
-She usually worked 3pm to 11pm.
-She did not recall the specifics of the 07/20/23 incident with client #5 since it was a month ago.
-Client #5 was outside of his room.
-Client #5 was in a behavior and trying to choke other clients.
-Client #5 was on the floor.
-It took 3 staff to "hold" client #5 but he was "never dragged."
-She remembered client #5 said someone touched his private parts "but no one did."

Interview on 08/29/23 QP #2 stated:
-She started working at the facility in June 2023.

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V 512	Continued From page 87 -She was the QP on second shift. -She recalled the incident with client #5 on 07/20/23. -She had to go to the agency office to complete paperwork about that incident today. -Client #5 was going around and choking the other clients. -We tried to prevent his behavior and client #5 "tried to punch and kick us." -When the incident report said "drag" it was more of "guide" client #5. -Because of staff "body size" we were trying to keep clients safe. -"Not a CPI hold just keeping people safe." -She met with the Director today, reviewed additional paperwork about physical interventions and wrote a statement. -Client #5 was not injured on 07/20/23. Finding #2: Review on 08/25/23 of FS #12's personnel record revealed: -Date of Hire: 03/01/23. -Job Title: Therapeutic staff Review on 08/25/23 of FS #13 personnel record revealed: -Date of hire: 06/28/23. -Job Title: Therapeutic staff. Review on 08/24/23 of client #5's record revealed: -13 year old male. -Admitted on 05/06/23. -Diagnoses of Disruptive Mood Dysregulation Disorder, Conduct Disorder, childhood onset type, Intellectual Developmental Disability, Mild, Child Physical Abuse, Child Psychological Abuse and Child Neglect.	V 512		

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Review on 08/25/23 of a facility surveillance video dated 08/22/23 revealed:
-The video did not offer audio.
-Approximately 1:59am, QP #1 left the facility.
-Staff #2 and FS #13 present with 6 clients.
-At 12:27pm, client #5 dragged client #8 by his feet out of his room. FS #13 stood still in the hallway with clients and watched. Once released by client #5, client #8 returned to his room. Client #5 had a face to face interaction with FS #12 before she directed him in the opposite direction and followed.
-12:29pm Client #5 went into client #8's bedroom and FS #13 went into client #8's bedroom and pushed client #5 about his body across the hall and into his (client #5) bedroom before client #5 ran out of his own bedroom while FS #13 was inside. Client #5 ran into the kitchen.
-12:32 - FS #13 gathered her food and drink and left the facility. FS #12 arrived from the sister facility.
-FS #12 removed client #5 from the kitchen and walked him to the hall. Client #5 fell to the ground and FS #12 picked client up under his arms with the client's back to the staff's and dragged client #5 into his bedroom.
-FS #12 left client #5's bedroom and client #5 followed behind him. FS #12 turned around and client #5 ran in the opposition direction down the hall.
-FS #12 struggled with client #5 pulling and pushing on his arms and body towards client #5's bedroom as client #5 resisted and dropped to the floor.
-Client #5 remained on the floor as FS #12 continued to pull about client #5's body to get him to his room.
-FS #12 grabbed client #5's leg as he sat on the floor and began to drag client #5 by his leg down the hall. Client #5's pants came down exposing

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his underwear. FS #12 released client #5's leg and grabbed client #5's shirt and continued to pull him as client #5 sat on the ground attempting to fix his torn and ripped pants.
-12:39pm - QP #1 returned to the facility and engaged client #5 as he stood in the hall attempting to fix his ripped clothing.
-12:44 pm - Client #5 had changed clothes and stood in the hall with QP #1, staff #2 and FS #12 before retreating to his room as FS #12 followed. Client #1 crawled backwards out of his bedroom in an apparent struggle with FS #12 and continued to remain on the floor.
-Client #5 scooted across on the hall on the floor and went into client #8's bedroom as staff FS #12 followed client #5 before he scooted back out.

Interview on 08/31/23 FS #12 stated:
-He had worked for the agency for approximately 3 years.
-He normally worked at the sister facility and had all his relevant training.
-He recalled the incident on 08/22/23.
-He was the only male staff at the facility and he was asked to come to the facility from the sister facility.
-A staff member met him at the door and gave him the keys. "I was like d**n."
-He grabbed client #5 and client #5 dropped to the floor and ripped his shirt.
-He was trying to keep the female staff safe but she would not help him.
-Client #5's pants ripped from the buttons.
-The episode lasted for about 15 or 20 minutes.
-The other staff would not help with client #5.
-The police came and he left.
-He was not supposed to be in the facility since he worked at the sister facility.
-He never worked in the facility and now he had to go to the office and speak with Human

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Resources and is out of work.
-More staff would have helped in the incident.
-He was trying to bring client #5 to his room.

Interview on 08/29/23 FS #13 stated:
-She worked at the facility for 2 months.
-She needed to call back to finish the interview.

Attempted interview by phone on 08/31/23 with FS #13 resulted in a voicemail message requesting a return call and by the exit date of 09/07/23 FS #13 had not returned the call.

Finding #3
Review on 08/28/23 of staff #5's personnel record revealed:
-Date of Hire: 06/14/23
-Job Title: Therapeutic staff.

Review on 08/28/23 of staff #11's personnel record revealed:
-Date of Hire: 06/05/23.
-Job Title: Therapeutic staff.

Review on 08/24/23 of client #1's record revealed:
-15 year old male.
-Admission date of 06/16/23.
-Diagnoses of Adjustment Disorder, with mixed disturbance of emotions and conduct, Oppositional Defiant Disorder and Mild Intellectual Developmental Disability.

Review on 09/07/23 of a North Carolina IRIS Report for client #1 revealed:
-Date and time of the incident: 08/18/23 at 4:30pm.
-"Describe the cause of this incident, (the details of what led to this incident). [Client #1] was complaining about [Client #5]. [Client #1] was

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upset because he felt it was not fair that [Client #5]'s punishment was removed due to the fact that the previous day [Client #5] put [Client #1] in a chokehold. [Client #5] overheard [Client #1] saying these things and began arguing with him. [Client #5]initiates the fight by saying "then do something." [Client #1] grabs a broom, as the consumers are in the middle of doing chores. [Client #5] grabs the dustpan and hits [Client #1]. Both consumers release the objects and began fist fighting. Staff A (unknown staff) and Staff B (unknown staff) rush to break them apart. They were refusing to calm down so staff C (unknown staff) was called from the front building. [Client #1] was still refusing to calm down so staff C placed him in a CPI hold. He is eventually able to calm down."

Review on 08/23/23 of facility surveillance video dated 08/18/23 revealed:
-4:08pm client #1 quickly stood up and left from the common area table and staff #5 and staff #11 followed up.
-Client #1 went in the opposite direction of the hall where his bedroom was located.
-Staff #11 wrapped his arm around client #1 waist and picked him up off his feet and headed down the hall before they both fell to the floor.
-After getting off the floor briefly, staff #11 continued to struggle with client #1 before falling to the floor again.
-While client #1 was still on the ground, staff #11 stood up and grabbed of client #1's ankles and pulled him down the hall to his bedroom as staff #5 followed.
-Staff #5 stood at client #1's bedroom door while staff #11 went into client #1's bedroom.
-At 4:11pm, client #1 left his bedroom. Staff #11 continued to have face to face interactions with client #1 as staff #5 watched.

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-Staff #5 held client #1's arm and directed him back to his bedroom holding his arm. Staff #5 stood at the bedroom door and staff #11 went inside.
-At 4:13 pm, client #1 ran past staff #5 and staff #11 as staff #11 quickly followed.
-Staff #11 caught client #1 midway down the hall as he fell to the floor.
-Client #1 was positioned face down as staff #11 picked him up from behind under his arms and dragged him down the hall.
-Client #1 fell to the ground and turned over facing up. Staff #5 and staff #11 each grabbed one arm of client #1 and dragged him to his room.

Interview on 08/29/23 client #1 revealed:
-He had been dragged by his feet and arms by staff.
-QP #2 was the staff that had dragged him.
-She was pulling him by his legs and Staff #17 had him by his arms.
-Staff #17 was the maintenance person.

Interview on 08/29/23 staff #5 stated:
-He worked at the facility since 06/14/23.
-He saw client #1 dragged down the hallway by staff #11.
-CPI did not teach staff to drag clients.

Interview on 08/31/23 staff #11 stated:
-He was assigned to the sister facility and worked for 2 months.
-He only went to the facility for client behaviors because there was only one male who worked there.
-He last worked in the facility about 3 weeks ago.
-He was called by staff #5 due to client #1 and client #5 fighting.
-Client #1 and client #5 were not fighting when he

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arrived but they were arguing back and forth.
-He had to pull client #1 by his arms because he had "dropped his weight and would not get up."
-He was not trained on what to do if a client was on the floor.
-Staff #5 was not able to help with restraint because he had a broken finger.
-He was made aware of client #1's allegation that he punched him by the lead QP the following Saturday when he returned to work.
-He had not punched client #1.

Interview on 08/28/23 and 09/05/23 the Residential Director/CPI Instructor stated:
-On 07/20/23, QP #2, staff #9, FS #14 and FS #15 were indentified on the facility security video.
-Client #5 should have received his as needed medication when he first started acting out.
-Client #5 was "not placed in a appropriate restraint" and she "does not train staff on anything with clients on the floor."
-The restraint "should not have lasted longer than 15 minutes."
-QP #2 should have "redirected" staff.
-She was unsure if an internal investigation was completed by the former lead QP.
-On 08/05/23, there were 3 staff (staff #5, staff #6 and staff #9) and QP #2 were scheduled to work.
-She was unsure why none of the staff scheduled to work were not at the facility.
-Staff #10 was the maintenance worker and worked as direct care staff as needed.
-Staff #16 worked at the sister facility and filled in at this facility.
-The incidents of client #1 and client #5 being dragged were "considered to be abusive."
-The facility should follow their policy and procedures for reporting abuse.

Review on 09/07/23 of the Plan of Protection

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V 512	Continued From page 94 dated 09/07/23 and completed by the Residential Director/CPI Insructor revealed: "-What immediate action will the facility take to ensure the safety of the consumers in your care? The QP, will ensure to notify the management team of the abuse, neglect, or exploitation allegation within 24 hrs (hours). QP, and the management team will meet when, allegation has been reported to QP, within 24 hours. Describe your plans to make sure the above happens. QP, will go to the facility within 30 minutes to an hour when harm, abuse, neglect, or exploitation has been reported. QP will instruct other staff that was not involved in the incident to remove consumer from the situation and stay with consumer until appropriate authorities get to the facility. QP will make sure all staff involved in the incident be taken off shift immediately until investigation is completed. QP, will begin the internal investigation by interviewing the involved consumer that are verbal and completing a full body check on verbal or non-verbal clients by documenting and put in the report. QP, will report any type of abuse, neglect, harm, exploitation to appropriate authorities such as DSS (Department of Social Services), NC Health Registry, Police, Guardian and RN (Registered Nurse). QP, will transport involved consumer to emergency room to be evaluated for any injuries if, any injuries are presented. The QP, will write investigation summary within 5 days after the initiating an on-site investigation. QP, will monitor daily any investigation that has been reported. The management team will monitor all incidents bi-weekly and at the weekly team meeting." The facility served children ages 10-17 years old with diagnoses to include Adjustment Disorder, ODD, ADHD, DMDD and IDD. On 07/20/22, client	V 512		

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V 512	Continued From page 95 #5 was dragged by his arms by staff #6 and FS #14 then restrained on the floor by the same staff and the QP #2. During the same incident the QP #2 failed to protect client #5 while watching staff #6 and FS #14 drag client #5. On 08/18/23, client #1 was picked up off the floor by staff #11 before they both fell to the floor. Client #1 was dragged down the hall by his ankle while on the floor by staff #11. Staff #5 was involved in dragging client #1 by his arms down the hall. On 08/22/23, client #5 was pushed and pulled about his body by FS #13. During the same behavior, client #5 was dragged down the hall by his legs which resulted in his shirt and pants being ripped from his body by FS #13. The Residential Director/CPI Instructor identified several facility staff engaged in abusive incidents of clients being dragged to their rooms. This deficiency constitutes a Type A1 rule violation for serious abuse and must be corrected within 23 days. An administrative penalty of $6,000.00 is imposed. If he violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for failure to correct within 23 days.	V 512		
V 519	27E .0104(e3-7) 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: (3) the process for identifying, training, assessing competence of facility employees who may authorize and implement restrictive interventions; (4) the duties and responsibilities of responsible professionals regarding the use of restrictive	V 519		

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V 519	Continued From page 96 interventions; (5) the person responsible for documentation when restrictive interventions are used; (6) the person responsible for the notification of others when restrictive interventions are used; and (7) the person responsible for checking the client's physical and psychological well-being and assessing the possible consequences of the use of a restrictive intervention and, in such cases there shall be procedures regarding: (A) documentation if a client has a physical disability or has had surgery that would make affected nerves and bones sensitive to injury; and (B) the identification and documentation of alternative emergency procedures, if needed; This Rule is not met as evidenced by: Based on record reviews and interview the facility failed to develop and implement policy and procedures for restrictive interventions as required. The findings are: Review on 08/25/23 of the facility policy for restrictive interventions revealed the following requirements were not included: -The process for identifying, training, assessing competence of facility employees who may authorize and implement restrictive interventions. -The duties and responsibilities of responsible professionals regarding the use of restrictive interventions. -The person responsible for documentation when restrictive were used. -The person responsible for the notification of others when restrictive interventions are used. -The person responsible for checking the client's physical and psychological well-being and	V 519		

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V 519	Continued From page 97 assessing the possible consequences of the use of a restrictive intervention. -Procedures for documentation if a client had a physical disability or has had surgery that would make affected nerves and bones sensitive to injury. -Procedures for the identification and documentation of alternative emergency procedures, if needed. Interview 09/05/23 the Residential Director/Crisis Prevention Institute Instructor stated: -The restrictive intervention policy was revised in 2018. -The current policy did not reflect the required language for restrictive interventions.	V 519		
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;	V 521		

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(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, 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 for 3 of 3 restrained clients (#1, #3 and #5). The findings are:

Finding #1:
Review on 08/24/23 of client #1's record revealed:
-15 year old male.
-Admission date of 06/16/23.
-Diagnoses of Adjustment Disorder, with mixed disturbance of emotions and conduct, Oppositional Defiant Disorder and Mild Intellectual Developmental Disability.
-No documentation of a description of the debriefing and planning with the client and the

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legally responsible person to reduce the probability of the future use of restrictive interventions.

Review on 09/07/23 of client #1's level I facility incident reports revealed:
-Client #1 had been placed in a "hold", "restrain" or "CPI" (Crisis Prevention Institute) on 07/08/23 at 5:00pm, 07/31/23 at 9:30am, 7/28/23 at 8:30pm, 07/25/23 at 7:30pm, 07/25/23 at 7:05pm, 08/17/23 at 9:00am, 08/05/23 at 5:00pm

Finding #2:
Review on 08/29/23 of client #3's record revealed:
-12 year old male.
-Admission date of 05/02/23.
-Conduct Disorder, Attention Deficit Hyperactivity Disorder combined and Disruptive Mood Dysregulation Disorder
-No documentation of a description of the debriefing and planning with the client and the legally responsible person to reduce the probability of the future use of restrictive interventions.

Review on 09/07/23 of client #3's level I facility incident reports revealed:
-Client #1 had been placed in a "hold" or "CPI" on 05/13/23 at 7:30am, 05/30/23 at 7:30am, 06/03/23 at 8:00am, 06/10/23 at 10:20am.

Review on 09/07/23 of North Carolina Incident Response Improvement System (IRIS) reports for client #3 revealed CPI or restrcitive interventions on the following dates and times:
-05/13/23 at 7:30am, 05/30/23 no time entered.

Finding #3:
Review on 08/24/23 of client #5's record

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V 521	Continued From page 100 revealed: -13 year old male. -Admitted on 5/6/23. -Diagnoses of Disruptive Mood Dysregulation Disorder, Conduct Disorder, childhood onset type, Intellectual Developmental Disability, Mild, Child Physical Abuse, Child Psychological Abuse and Child Neglect. -No documentation of a description of the debriefing and planning with the client and the legally responsible person to reduce the probability of the future use of restrictive interventions. Review on 09/07/23 of client #5's level I facility incident reports revealed: -Client #1 had been placed in a "hold" or "CPI" on 07/08/23 at 5:00pm, 7/28/23 at 8:30pm, 07/20/23 at 8:30pm, Interview on 09/05/23 the Residential Director/CPI Instructor stated: -Staff should be debriefing after restrictive interventions. -Staff should be documenting the specifics regarding the type of holds and length of holds.	V 521		
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	V 524		

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V 524	Continued From page 101 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 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 notify the guardian immediately following a restrictive intervention or members of	V 524		

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V 524	Continued From page 102	V 524		

the treatment team affecting 1 of 3 audited restrained clients (#3). The findings are:

Review on 08/29/23 of client #3's record revealed:
-12 year old male.
-Admission date of 05/02/23.
-Conduct Disorder, Attention Deficit Hyperactivity Disorder combined and Disruptive Mood Dysregulation Disorder

A. Review on 08/29/23 of a North Carolina IRIS (Incident Response Improvement System) report for client #3 revealed:
-Date and time of the incident: 05/13/23 at 7:30am.
-Provider Comments: "[Client #3] started the morning with a behavior after being told he could not watch tv because he was cursing. [Client #3] stormed to his room and one staff (unknown staff) member followed. [Client #3] was not listening to the staff (unknown staff) and when I (unknown staff) entered the room, [Client #3] was sitting on the floor banging his head on the wall. After continuing not to listen, staff (unknown staff) picked [Client #3] up and placed him on his bed. [Client #3] started to kick the staff (unknown staff) member so [Client #3]'s legs and arms were held still. [Client #3] started crying so staff (unknown staff) talked to him about why he was told that he could not watch tv at that time. Staff (unknown staff) told [Client #3] that if he calmed down, he could be let go and talk to be better understood. [Client #3] agreed to let consumers A, B, and C (unknown clients) play the game and [Client #3] could watch tv by himself."
-"Describe the cause of this incident, (the details of what led to this incident). [Client #3] started the morning with a behavior after being told he could not watch tv because he was cursing. [Client #3]

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stormed to his room and one staff member (unknown staff) followed. [Client #3] was not listening to the staff (unknown staff) and when I (unknown staff) entered the room, [Client #3] was sitting on the floor banging his head on the wall. After continuing not to listen, staff (unknown staff) picked [Client #3] up and placed him on his bed. [Client #3] started to kick the staff member (unknown staff) so [Client #3]'s legs and arms were held still. [Client #3] started crying so staff (unknown staff) talked to him about why he was told that he could not watch tv at that time. Staff (unknown staff) told [Client #3] that if he calmed down, he could be let go and talk to be better understood. [Client #3] agreed to let consumers A, B, and C (unknown clients) play the game and [Client #3] could watch tv by himself."
-"Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. Taking steps to control stressors and talking with therapist."
-Guardian notified 05/30/23 per IRIS report
-Completed by Former Qualified Professional (QP) #3.

Review on 08/29/23 of a facility level I incident report for client #3 revealed:
-Date and time of the incident: 05/13/23 at 7:30am.
-Narrative: "[Client #3] started the morning with a behavior after being told he could not watch TV because he was cursing. [Client #3] stormed to his room & one staff member (unkown staff) followed. He was not listening to the staff (unknown staff) & when I [Staff #1] entered the room he was sitting on the floor banging his head on the wall. After continuing not to listen staff (unknown staff) picked him up & placed him on

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his bed & he started to kick a staff (unknown staff) member, so we held his legs & arms still. He started crying so staff (unknown staff) talk to him about why he was told he could not watch TV at that time & if he calmed down he could be let go & talk so he could be understood. He agreed to letting consumers A, B. & C (unknown clients) play game & he could watch TV by his self."
-No documentation the guardian was notified.
-Signed narrative staff #1.

B. Review on 08/31/23 of an North Carolina IRIS report for client #3 revealed:
-Date of incident: 05/30/23.
-Provider Comments: "[Client #3] was told he could not play the game or watch tv due to his behavior on 2nd shift. [Client #3] became angry due to a staff (unknown staff) member turning off the tv. [Client #3] pulled the fire alarm and stormed off to the bathroom. [Client #3] closed the bathroom door. Two staff members (unknown staff) walked [Client #3] to his room and a staff member (unknown staff) blocked the door so that [Client #3] could not leave his room due to the behavior. [Client #3] began scratching himself on his leg. Staff (nknown taff) was successfully able to get [Client #3] to stop scratching himself. The staff member (nknown taff) that was guarding the door became the target of [Client #3]'s aggression. [Client #3] began punching, kicking and attempted to bite the staff member (unknown staff). [Client #3] was placed in a CPI (Crisis Prevention Institute) hold for 5-10 minutes."
-"Describe the cause of this incident, (the details of what led to this incident). [Client #3] was told he could not play the game or watch tv due to his behavior on 2nd shift. [Client #3]became angry due to a staff member (unknown staff) turning off the tv. [Client #3] pulled the fire alarm and stormed off to the bathroom. [Client #3] closed

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the bathroom door. Two staff members (unknown staff) walked [Client #3] to his room and a staff member (unknown staff) blocked the door so that [Client #3] could not leave his room due to the behavior. [Client #3] began scratching himself on his leg. Staff (unknown staff) was successfully able to get [Client #3] to stop scratching himself. The staff member (unknown staff) that was guarding the door became the target of [Client #3]'s aggression. [Client #3]began punching, kicking and attempted to bite the staff member (unknown staff). [Client #3] was placed in a CPI hold for 5-10 minutes."
-"Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. Management will continue to monitor the safety of the staff (unknown staff) and the safety of the consumers daily. Therapist can advise."
-Guardian notified 05/15/23 per IRIS report.
-Completed by Former QP #3.

Review on 08/29/23 of a facility level I incident report for client #3 revealed:
-Date and time of the incident: 05/30/23 at 7:30am.
-Staff completing form: House Manager.
-Narrative: "[Client #3] was told he could not play the game or watch TV due to his behavior on 2nd shift. He got mad because Ms. [Staff #1] turn the tv off. He pulled the fire alarm and storm off to the bathroom. He close the bathroom door. Me (unknown) and staff one (Unknown staff) walk him to his room and I (unknown staff) was blocking the door so he could not get out. He started scratching himself on his leg. We got him to stop. I (unknown staff) was standing in front of the door and he started punching me and kicking me then he tried to bite me. I put him in a CPI

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hold for 5-10 min (minutes)."
-No documentation the guardian was notified.
-Staff #1 signed the narrative.
-Unknown initials dated 05/30/23 on the narrative as well.

C. Review on 08/24/23 of a facility level 1 incident report for client #3 revealed:
-Date and time of the incident: 06/03/23 at 8:00am.
-Staff completing form: Former QP #3.
-Narrative:"[Client #3] woke up around 8:00am being non compliant. He ran into the med room attempting to push staff (unknown staff) out of the way to get his computer that was locked up. His computer was taken and the med (medication) room was locked which caused him to go into a behavior. He was hitting his head and kicking windows and doors. He had to be restrained to prevent him from harming himself. While being restrained he attempted to kick and bite staff (unknown staff)."

D. Review on 08/24/23 of a facility level 1 incident report for client #3 revealed:
-Date and time of the incident: 06/10/23 at 10:20am.
-Staff completing form: Former QP #3.
-Narrative: "[Client #3] has been non-compliant to staff (unknown staff) all morning. He was asked to go to his room unti lhe calmed down, but stormed off into a room that wasn't his. He was asked to come out of the room but he refused so staff (unknown staff) escorted him to his room. He started spitting popcorn seeds at me (unknown staff) and using profanity calling me a 'B***h.' He kept spitting at me and kicking me so he had to be put in a restraint. He finally calmed down but he had to be restrained in his room for at least 15 mintues."

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V 524	Continued From page 107 Interview on 09/01/23 the legal guardian representative for client #3 stated: -She had not been informed about any restrictive interventions and did not have any knowledge of restrictive interventions used on client #3. Interview on 09/07/23 the Residential Director/CPI Instructer stated: -She was just made aware client #3's guardian had not been notified of restrictive interventions. -Guardians should be notified of restrictive interventions.	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 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;	V 525		

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V 525	Continued From page 108 (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 review and interviews, the facility failed to maintain a restrictive intervention log. The findings are: Review on 08/24/23 of facility records revealed no restrictive intervention log. Interview on 08/24/23 the Lead Qualified Professional (QP) stated: -She had started to work at the facility approximately 3 weeks ago. -She had not seen a restrictive intervention log. Interview on 09/05/23 the Residential Director/Crisis Prevention Institute Instructor stated: -A restraint log had been completed in the past. -She was not aware of a current restraint log. -A restraint log should be maintained for restrictive interventions.	V 525		
V 526	27E .0104(e18-19) Client Rights - Sec. Rest. & ITO	V 526		

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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:
(18) The facility shall collect and analyze data on the use of seclusion and physical restraint. The data collected and analyzed shall reflect for each incident:
(A) the type of procedure used and the length of time employed;
(B) alternatives considered or employed; and
(C) the effectiveness of the procedure or alternative employed.
The facility shall analyze the data on at least a quarterly basis to monitor effectiveness, determine trends and take corrective action where necessary. The facility shall make the data available to the Secretary upon request.
(19) Nothing in this Rule shall be interpreted to prohibit the use of voluntary restrictive interventions at the client's request; however, the procedures in this Rule shall apply with the exception of Subparagraph (f)(3) of this Rule.

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to collect and analyze data as required for the use of seclusion and physical restraints. The findings are:

Review on 08/25/23 and 09/07/23 of facility records revealed:
-No quarterly collection or analysis on the use of physical restraints at the facility.

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V 526	Continued From page 110 Interview on 09/05/23 and 09/07/23 the Residential Director/Crisis Prevention Institute Instructor stated: -We had a client rights committee in the past (sister facility) to review restraints. -We should have been doing this from the beginning. -No documentation of any meetings for the facility. -We will have to work on resolving the issue of data collection. -We have a new management team coming to help assist with operations.	V 526		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of	V 537		

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V 537	Continued From page 111 training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain	V 537		

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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 537	Continued From page 112 documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and	V 537		

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V 537	Continued From page 113 (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers.	V 537		

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This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure staff demonstrated competency in restrictive interventions for 4 of 13 audited staff (#1, #5, House Manager and Qualified Professional (QP) #1) . The findings are:

Review on 08/29/23 of client #3's record revealed:
-12 year old male.
-Admission date of 05/02/23.
-Conduct Disorder, Attention Deficit Hyperactivity Disorder combined and Disruptive Mood Dysregulation Disorder

A: Review on 08/29/23 of a North Carolina Incident Response Improvement System (IRIS) report for client #3 revealed:
-Date and time of the incident: 05/13/23 at 7:30am.
-Provider Comments: "[Client #3] started the morning with a behavior after being told he could not watch tv because he was cursing. [Client #3] stormed to his room and one staff (unknown staff) member followed. [Client #3] was not listening to the staff (unknown staff) and when I entered the room, [Client #3] was sitting on the floor banging his head on the wall. After continuing not to listen, staff (unknown staff) picked [Client #3] up and placed him on his bed. [Client #3] started to kick the staff (unknown staff) member so [Client #3]'s legs and arms were held still. [Client #3] started crying so staff (unknown staff) talked to him about why he was told that he could not watch tv at that time. Staff (unknown staff) told [Client #3] that if he calmed down, he

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could be let go and talk to be better understood. [Client #3] agreed to let consumers A, B, and C (unknown clients) play the game and [Client #3] could watch tv by himself.
-Describe the cause of this incident, (the details of what led to this incident). [Client #3] started the morning with a behavior after being told he could not watch tv because he was cursing. [Client #3] stormed to his room and one staff (unknown staff) member followed. [Client #3] was not listening to the staff (unknown staff) and when I entered the room, [Client #3] was sitting on the floor banging his head on the wall. After continuing not to listen, staff (unknown staff) picked [Client #3] up and placed him on his bed. [Client #3] started to kick the staff (unknown staff) member so [Client #3]'s legs and arms were held still. [Client #3] started crying so staff (unknown staff) talked to him about why he was told that he could not watch tv at that time. Staff (unknown staff) told [Client #3] that if he calmed down, he could be let go and talk to be better understood. [Client #3] agreed to let consumers A, B, and C (unknown clients) play the game and [Client #3] could watch tv by himself.
-Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. Taking steps to control stressors and talking with therapist."
-Person completing IRIS report QP #3.

Review on 08/29/23 of a facility level I incident report for client #3 revealed:
-Date and time of the incident: 05/13/23 at 7:30am.
-Narrative: "[Client #3] started the morning with a behavior after being told he could not watch TV because he was cursing. [Client 3] stormed to his

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room & one staff (unknown staff) member followed. He was not listening to the staff (unknown staff) & when I entered the room he was sitting on the floor banging his head on the wall. After continuing not to listen staff (unknown staff) picked him up & placed him on his bed & he started to kick a staff (unknown staff) member, so we held his legs & arms still. He started crying so staff (unknown staff) talk to him about why he was told he could not watch TV at that time & if he calmed down he could be let go & talk so he could be understood. He agreed to letting consumers A, B. & C (unknown clients) play game & he could watch TV by his self."
-Signed by staff #1.

B: Review on 08/31/23 of an North Carolina IRIS report for client #3 revealed:
-Date of incident: 05/30/23.
-Provider Comments: "[Client #3] was told he could not play the game or watch tv due to his behavior on 2nd shift. [Client #3] became angry due to a staff (unknown staff) member turning off the tv. [Client #3] pulled the fire alarm and stormed off to the bathroom. [Client #3] closed the bathroom door. Two staff (unknown staff) members walked [Client #3] to his room and a staff (unknown staff) member blocked the door so that [Client #3] could not leave his room due to the behavior. [Client #3] began scratching himself on his leg. Staff (unknown staff) was successfully able to get [Client #3] to stop scratching himself. The staff (unknown staff) member that was guarding the door became the target of [Client #3]'s aggression. [Client #3] began punching, kicking and attempted to bite the staff (unknown staff) member. [Client #3] was placed in a CPI (Crisis Prevention Institute) hold for 5-10 minutes.
-Describe the cause of this incident, (the details of what led to this incident). [Client #3] was told

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he could not play the game or watch tv due to his behavior on 2nd shift. [Client #3]became angry due to a staff (unknown staff) member turning off the tv. [Client #3] pulled the fire alarm and stormed off to the bathroom. [Client #3] closed the bathroom door. Two staff (unknown staff) members walked [Client #3] to his room and a staff (unknown staff) member blocked the door so that [Client #3] could not leave his room due to the behavior. [Client #3]began scratching himself on his leg. Staff (unknown staff) was successfully able to get [Client #3]to stop scratching himself. The staff (unknown staff) member that was guarding the door became the target of [Client #3]'s aggression. [Client #3]began punching, kicking and attempted to bite the staff (unknown staff) member. [Client #3] was placed in a CPI hold for 5-10 minutes.
-Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. Management will continue to monitor the safety of the staff and the safety of the consumers daily. Therapist can advise."
-Person completing IRIS report QP #3.

Review on 08/29/23 of a facility level I incident report for client #3 revealed:
-Date and time of the incident: 05/30/23 at 7:30am.
-Staff completing form: House Manager.
-Narrative: "[Client #3] was told he could not play the game or watch TV due to his behavior on 2nd shift. He got mad because Ms. [Staff #1] turn the tv off. He pulled the fire alarm and storm off to the bathroom. He close the bathroom door. Me and staff (unknown staff) one walk him to his room and I was blocking the door so he could not get out. He started scratching himself on his leg. We

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got him to stop. I was standing in front of the door and he started punching me and kicking me then he tried to bite me. I put him in a CPI hold for 5-10 min (minutes)."
-Staff #1 signed the incident report.
-Unknown initials indicated on the incident report.

During interview on 08/30/23 client #3 revealed:
-He had been restrained.
-Sometimes he was restrained on the wall, the floor and the bed.
-He was laying flat and the staff (did not identify names) had his arms and his legs.
-Your arms are behind you and the staff pull the arms up and twist them.
-He was laying face down on the bed.
-When he was restrained his wrist would turn red and it would "hurt a little bit."

During interview on 09/01/23 client #6 revealed:
-He had not lived at the facility long.
-A staff "closed" him in his room because he was having a "behavior."
-He wanted water and the staff would not give him the water (He identified staff #5 first then identified the House Manager).(The QP #1 was the actual staff that held him in his room)
-He was trying to get out of the bedroom but the QP #1 was holding the door.
-He was yelling "let me out."
-He had been restrained.
-The staff put his arms behind his back.
-"[Staff #5] did it."
-He was restrained a "couple of weeks ago."
-"It hurt when he was doing it."

During interview on 08/30/23 client #8 revealed:
-He was easy to restrain because he was "little."
-He did not remember the staff that had restrained him.

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-When you are restrained you are put in a "chicken hold."
-[Staff #5] had restrained him.
-The staff "put your hands behind your back and hold you on the bed face down."
-He had his "face turned" but he was "laying down on his stomach."
-All of his restraints had been "done that way."

During interview on 08/29/23 staff #5 revealed:
-He had placed clients in a restraint.
-"You can restrain clients on the bed."
-If the client were on the bed we "hold them and tell them to calm down and relax."

During interview on 08/29/23 and 08/31/23 staff #1 revealed:
-She had seen restraints done on the bed.
-CPI did not teach you to restrain on the bed.
-She witnessed QP #1 "hold the door shut" and not let client #6 out of his room.
-She used a chair and "continued to hold the door."
-Client #6 was "yelling and wanted to get out."
-Client #6 was mad and crying because QP #1 would not let him out of his room.
-She was able to go into client #6's room and calm him down.
-When a restraint is done on the bed the client is "face down."

During interview on 08/31/23 the House Manager revealed:
-When a restraint was done on the bed the client is face down on the stomach.
-"You don't do the restraint hard because you don't want to suffocate them when doing a restraint."

Interview was attempted on 08/31/23 with QP #1

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and was unsuccessful due to the phone number not being a working number and there was no other phone number to reach QP #1.

During interview on 09/01/23 the Residential Director/Crisis Prevention Institute Instructor revealed:
-She was the CPI instructor.
-Staff had not been trained in face down restraints.
-She trained them for "no head lock, no bed."
-"If they fall to the floor you release them."
-The restraints they were using they "had not been trained for."
-QP #1 did not work at the facility.
-She was fired Thursday (08/31/23) or Friday (09/01/23).
-She had "restrained a client and was not supposed to."
-She held the door of client #6 and would not let him out of his room.

Review on 09/01/23 of the Plan of Protection dated 09/01/23 and completed by the Lead QP revealed:
"-What immediate action will the facility take to ensure the safety of the consumers in your care?
The facility will ensure that all CPI holds are done appropriately by each trained staff. Staff and consumers will be monitored by the Lead QP on camera throughout the shifts. Any inappropriate or untrained skills being used throughout the shift will result in Immediate action to remove that staff member until further notice.
Describe your plans to make sure the above happens.
The plan is to monitor them or camera throughout the shift and when a consumer demonstrates aggressive behavior the Lead QP will call the staff

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to walk them through the behavior. Also the QP on shift will be informed to monitor staff at all times during aggressive or destructive behaviors and report to lead QP only."

The facility was licensed to provide intensive residential treatment for children and served clients with diagnoses to include Adjustment Disorder, ODD, ADHD, DMDD and Intellectual Developmental Disabilities. The clients ages ranged from 10 - 17 years old. The staff at the facility did not show competency in properly restraining the clients. The Residential Director of the facility was the CPI instructor for the staff at the facility and revealed the staff had never been trained to complete restraints with arms behind the back or on the bed. Clients were being restrained on their bed face down and also being restrained with their arms behind their backs. The clients described discomfort and referred to the restraints as chicken holds. The QP #1 restrained client #6 in his bedroom by holding the door closed and not allowing him access to leave the room while he was yelling and crying to be let out of the room and asking for water. This deficiency constitutes a Type A2 rule violation for substantial risk of serious harm and abuse and must be corrected within 23 days. No administrative penalty has been assessed. If the violation is not corrected within 23 days, an administrative penalty of $500.00 per day will be imposed for each day the facility is out of complaince beyond the 23rd day.