STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE VILLAGE HOUSE	**2722 CATALINA AVENUE CHARLOTTE, NC 28206**

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on October 11, 2023. The complaint was substantiated (Intake #NC00207769). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolscents. This facility is licensed for 4 and currently has a census of 4. The survey sample consisted of audits of 4 current clients.	V 000		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four	V 296		

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children or adolescents;
(2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and
(3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents.
(d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan.
(e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan.

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

Review on 10/4/23 of Client #1's record revealed:
- Admitted 8/21/23;
- Age 11;
- Diagnoses: Other Specified Trauma and Stressor- Related Disorder, Oppositional Defiant Disorder, History of Neglect in Childhood.

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V 296	Continued From page 2 Review on 10/4/23 of Client #2's record revealed: - Admitted 5/31/23; - Age 11; - Diagnoses: Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Intellectual Disabilities Disorder, Mild, Adjustment Disorder. Review on 10/11/23 of Client #3's record revealed: - Admitted 8/25/23; - Age 17; - Diagnosis Post Traumatic Stress Disorder Review on 10/11/23 of Client #4's record revealed: - Admitted 5/3/23; - Age 18; - Diagnoses: Disruptive Mood Dysregulation Disorder; Attention Deficit Hyperactivity Disorder, Combined Type; Conduct Disorder, Adolescent Onset Type; Cannabis Use Disorder. Interview on 10/3/23 with Client #2 revealed: - "One staff was at the YMCA (Young Men's Christian Association)" with Client #1 and Client #2 on 9/22/23; - "I don't know many work with us." Interview on 10/4/23 with Client #3 revealed: - Two staff worked each shift; - "It depends on the date and occasion for the staff to split up and take two clients a piece. It would be an older client and a younger client so that the younger clients don't be bickering." - "Normally we all go together." Interview on 10/3/23 with the local YMCA supervisor revealed: - Staff #1 was alone with Client #1 and Client #2	V 296		

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V 296	Continued From page 3 at the YMCA on 9/22/23. Interview on 10/10/23 with Staff #1 revealed: - Two staff worked each shift; - " It was just that one day (9/22/23) when we (staff) split up and I took the younger two clients (Client #1, Client #2) with me to the YMCA." Interview on 10/10/23 with Staff #2 revealed: - Two staff worked each shift; - On 9/22/23, "Was the only time, we (staff) split up and he (Staff #1) took the younger clients to the YMCA and I took the other client with me to pick up [Client #4]." Interview on 10/4/23 with the Owner revealed: - Two staff worked on each shift; - Staff #1 was alone at the YMCA on 9/22/23 with Client #1 and Client #2; - Staff #2 was alone with Client #3 when he picked up Client #4 from work; - "I spoke with them (Staff #1 and Staff #2) about making sure there were two staff, but they still chose to split up."	V 296		
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	V 512		

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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:
Based on record reviews and interviews 1 of 2 paraprofessionals audited (staff #1) abused and neglected 2 of 4 clients (client #1, client #2). The findings are:

Review on 10/4/23 of Client #1's record revealed:
- Admitted 8/21/23;
- Age 11;
- Diagnoses: Other Specified Trauma and Stressor- Related Disorder, Oppositional Defiant Disorder, History of Neglect in Childhood.

Review on 10/4/23 of Client #2's record revealed:
- Admitted 5/31/23;
- Age 11;
- Diagnoses: Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Intellectual Disabilities Disorder, Mild, Adjustment Disorder.

Review on 10/4/23 on staff #1's personnel record revealed:
- Hire date 9/4/23;

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V 512	Continued From page 5 - Job title Direct Care Staff. Review on 10/9/23 and 10/10/23 of the local YMCA (Young Men's Christian Association) video surveillance inside pool area dated 9/22/23 revealed: - Staff #1 was alone with Client #1 and Client #2 at local YMCA; - Lead lifeguard was talking with Client #1 and Client #2 while they were in the pool; - Client #1 and Client #2 were splashing water on the lifeguard; - Staff #1 stood on the side of the pool; - Lead lifeguard jumped in the pool, grabbed Client #1 and put him on the outside of the pool; - Staff #1 grabbed Client #1 by the shirt from behind with one hand and walked him over to a chair, then shoved him down into the chair; - Client #1 got back up and went between staff #1's legs and jumped back into the pool; - Lead lifeguard then got Client #2 out of the pool, Client #2 then ran on the side of the pool with his pants down, exposed his private area, Staff #1 grabbed Client #2 by the back of his shirt with one hand and walked him over to the chair and shoved him down in the chair; - Client #2 was able to get away from Staff #1 and jumped back in the pool; - Staff #1 sat down in the chair; - Lead lifeguard got back into the pool; - Staff #1 was on the telephone walking around the side of the pool; - YMCA supervisor and YMCA security guard entered the pool area and attempted to talk to Client #1 and Client #2, and they splashed water on the YMCA supervisor and YMCA security guard; - Two lifeguards jumped into the pool to get clients out of the pool; - Lead lifeguard grabbed Client #1 and put him on	V 512		

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the side of the pool;
- Staff #1 grabbed Client #1 by the wrist, then tried to grab his other hand, Client #1 was moving around, Staff #1 then took about 2 steps and dragged Client #1 while Staff #1 was walking, he stopped and tried to get Client #1 to stand up on his feet, Client #1 was moving all around on the floor;
-Staff #1 lifted Client #1 up in the air, by his wrist and then picked him up around the waist and placed him in a chair, Client #1 was kicking and moving all around;
- Staff #1 continued to have Client #1 by the wrist and started to walk over to another chair, they took approximately 6 steps before client fell to the floor again.
- Staff #1 attempted to get Client #1 to sit in the chair but Client #1 was kicking and knocked the chair over;
- Staff #1 started to walk toward the outside door while he held Client #1's wrist, Client #1 fell to the floor and Staff #1 took about 6 steps while dragging Client #1 on the floor;
- Client #1 stood back up and Staff #1 pulled Client #1 outside while holding Client #1's wrist;
- Lead lifeguard walked Client #2 inside the pool to the side to climb out of the pool;
- Lead lifeguard then guided Client #2 with his hands on his shoulders along the side of the pool and out of the outside door.

Review on 10/9/23 and 10/10/23 of a local YMCA video surveillance of the parking lot revealed:
- Client #1 was seen on the ground kicking, unable to see what was happening due to a tree blocking the complete view;
- Staff #1 pulled up to the curb with the car;
- Staff #1 got out of the car and grabbed Client #1's wrist while YMCA staff was holding both of Client #1's hands and took him to the car to get

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V 512	Continued From page 7 inside. - Lead lifeguard walked Client #2 to the car to get inside; - Staff #1 drove off with client #1 and client #2 in the car. Review on 10/11/23 of the Internal Investigation Form dated 10/4/23 revealed: - Allegation "An incident occurred at the YMCA on 9/29/23 (9/22/23). The Village House managerial staff opened an investigation. The allegations include The Village House staff choking and neglecting clients at the YMCA." - Staff Statement: "[Staff #1] statement: 'clients refused to get out of the pool. Took 40 minutes to get them out. They continued to jump back in after being taken out of the pool and YMCA staff helped put them in the car. The clients peed in the car and were not following directions.'" - Client Statements: "[Client #1] statement: '[client #1] did not respond to any questions. He would only play with toys and say he wanted to go back in the pool.'" " [Client #2] statement: '[Client #2] stated that he was just coping [Client #1] and he didn't want to get out of the pool. Both clients denying being choked and slammed. Pictures were taken by CPS (Child Protective Services) and it was determined that both clients did NOT have any bruises or injuries.'" -" Summary of Investigation: The investigation determined that staff was not in ratio. Therefore, staff was placed on suspension until a thorough investigation was completed. The investigation revealed that staff split up clients to go on separate outings without management approval. After reviewing surveillance, management determined that there was evidence of inappropriate de-escalation techniques utilized (dragging client (Client #1) by his arm).	V 512		

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- Plan of Correction: after the investigation, management determined that [Staff #1]'s behavior was inappropriate. [Staff #1] was suspended effective 10/4/23. [Staff #1] will be required to take additional CPI (Crisis Prevention Intervention) training scheduled for 10/18/23. Once DHHS (Department of Human Health Services) completes their investigation, it will be determined if further actions are needed."

Review on 10/11/23 of the Employee Disciplinary Form revealed:
-Warning Date: 10/4/23;
-Type of Warning: First Warning;
- Description of Violation: "An incident occurred at the YMCA on 9/29/2023. The Village House managerial staff opened an investigation. The investigation determined that staff was not in ratio. Staff was placed on suspension until a thorough investigation was completed. the investigation revealed that staff split up clients to go on separate outings without management approval. After reviewing surveillance, management determined that there was evidence of inappropriate de-escalation techniques exhibited by dragging client by his arm to remove client from the YMCA pool.";
- Plan For Improvement: "[Staff #1]'s behavior was deemed inappropriate. [Staff #1] is required to take additional de-escalation training. [Staff #1] will remain on suspension until additional de-escalation training has been completed. Additional de-escalation training has been scheduled for 10/18/23. Once DHHS completes their investigation, it will be determined if further actions are needed."

Review on 10/11/23 of the Employee Disciplinary Form revealed:
-Warning Date: 10/4/23;

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-Type of Warning: Verbal
- Description of Violation: "An incident occurred at the YMCA on 9/29/2023. The Village House managerial staff opened an investigation. The investigation determined that staff was not in ratio. Staff was placed on suspension until a thorough investigation was completed. the investigation revealed that staff split up clients to go on separate outings without management approval.";
- Plan For Improvement: "Staff #2] was provided with a warning regarding his behavior. Policies and procedures were reiterated with staff."

Interview on 10/3/23 with Client #1 revealed:
- Denied being choked, slammed or dragged by anyone since being at the facility.
- "I don't know what happened at the YMCA" on 9/22/23.

Interview on 10/3/23 with Client #2 revealed:
- Staff #1 would not allow clients to have scuba gear while at the pool on 9/22/23.
- "So when it was time to go, I was fighting the lifeguards to get off me."
- A lady was trying to choke Client #1 at the YMCA on 9/22/23.
- "I started punching the staff at the YMCA, until he got off me, and I gave the lady a black eye."
- "She (YMCA supervisor) caused us (Client #1, Client #2) to act out because she called security."

Interview on 10/3/23 with the local YMCA Supervisor revealed:
- Was asked by a lifeguard to contact security to get two clients out of the pool, staff #1 was unable to get them out of the pool;
- Client #1 and Client #2 were splashing water and used foul language toward the lifeguards;
- Two lifeguards got into the pool and got them

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(Client #1, Client #2) out of the pool;
- The lead lifeguard got the smaller guy (Client #1) out of the pool;
- Client #1 tried to break away from staff #1;
- Staff #1 "dragged" client #1 out of the pool;
- The guardian took the smaller guy (Client #1) outside the back door and you could see them on the ground;
- Held Client #1 down on the ground until becoming fatigued while staff #1 went to get the car;
- Lead lifeguard held Client #1 on the ground until Staff #1 came back with the car;
- Talked to Client #1 to try and get him to calm down, but he just screamed;
- Lead lifeguard assisted with getting Client #1 into the car;
- Client #2 flashed himself when he got out of the pool;
- Client #2 wasn't as aggressive as Client #1;
- There was only one staff with the two clients;
- Staff #1 was "frustrated."

Interview on 10/3/23 with the local YMCA front desk member services representative revealed:
- Client #1 was screaming and throwing chairs;
- Staff #1 was tugging with Client #1 in the grass;
- YMCA Supervisor took over and held Client #1 while Staff #1 went to get the car;
- Client #1 was throwing items in the car;
- Client #2 showed himself (exposed private area) and then pulled his clothes back up.

Interview on 10/10/23 with the local YMCA Lead Lifeguard revealed:
- Was told Client #1 and Client #2 did not want to get out of the pool;
- "Their behavior was not the best or their language."
- Client #1 and Client #2 refused to get out of the

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pool;
- Assisted another guard with getting Client #1 and Client #2 out of the pool;
- Staff was "rough" with clients once they were out of the pool;
- Staff #1 told the lead lifeguard he was not getting in the pool, to try to get the clients out of the pool.

Interview on 10/10/23 with the local YMCA Lifeguard revealed:
- Staff #1 tried to get Client #1 and Client #2 out of the pool;
- Staff #1 asked the lead lifeguard to assist with getting the clients out of the pool;
- After 20 minutes of asking them to get out of the pool, Client #1 and Client #2 started getting "rowdy and we had to get in the pool to get them out of the pool;"
- Client #1 was going limp and fell down when Staff #1 got him from YMCA staff from out of the pool;
- Staff #1 dragged the client (#1) out the back door.

Interview on 10/10/23 with Staff #1 revealed:
- Was at the YMCA on 9/22/23 with Client #1 and Client #2;
- Client #1 and Client #2 refused to get out of the pool;
- Asked the lifeguard to assist with getting clients out of pool;
- Both clients were being defiant by cussing and splashing water on the staff at the YMCA;
- Denied choking either of the clients at the YMCA;
- Held Client #1 by the wrist when he got out of the pool, Client #1 kept falling to the ground, "I was trying to calm him down when I pulled client by the arm;"

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- "I pulled his arm, I wasn't dragging him."
- "Pulling of the arm was learned in CPI (Crisis Prevention Intervention), as a last resort for restraint."

Interview on 10/11/23 with the CPI Instructor who trained the facility staff revealed:
- Pulling a client's arm is not a technique taught in CPI;
- "Nah, no, dragging a client was never taught as a technique"

Interview on 10/3/23 and 10/10/23 with the Owner revealed:
- Learned on 10/3/23 of allegations of staff #1 harming clients while at the YMCA on 9/23/23.
- Started internal investigation on 10/4/23;
- Suspended staff #1 on 10/4/23;
- Department of Human Health Services (DHHS) opened an investigation on 9/24/23;
- Watched video surveillance with DHHS and able to see staff #1 push client #1 and client #2 into their seat and drag client #1 on the floor;
- Staff #1 was signed up for CPI training on 10/18/23.

Review on 10/11/23 of the Plan of Protection signed by Executive Director dated 10/11/23 revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care? An internal investigation was completed and it was determined that staff was not in ratio. Staff was placed on suspension until investigation was completed. Staff split up clients to go on separate outings without management approval. Management determined that there was evidence of inappropriate de-escalation techniques exhibited. Staff is required to take additional de-escalation training. Staff will remain on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601528	A. BUILDING: ______ B. WING ______	R-C 10/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE HOUSE	2722 CATALINA AVENUE CHARLOTTE, NC 28206

(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 512	Continued From page 13	V 512		

suspension until additional training is completed.
 Describe your plans to make sure the above happens.
Additional de-escalation training has been scheduled for 10/18/2023. Once DHHS completes their investigation, it will be determined if further actions are needed."

The facility served 4 clients ranging in ages from 11-18 years old with diagnoses of Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Intellectual Disabilities Disorder, Mild, Adjustment Disorder, Post Traumatic Stress Disorder and History of Neglect in Childhood. On 9/22/23, Client #1 and Client #2 were supervised by only one staff at the local YMCA. Staff #1 directed the clients to leave the pool and the clients refused. The YMCA staff intervened due to the clients' aggressive acting out behaviors, and their splashing water on the YMCA staff and refusing to leave the pool. Staff #1 grabbed the clients, individually and at different times, by their shirts and pushed the clients into a chair for them to sit down. Staff #1 was unable to gain control of the situation. Staff #1 lifted client #1 up in the air, by his wrist and then picked him up around the waist and placed him in a chair and held client #1 by the wrist and dragged client #1 on the floor approximately 4 feet away from the pool and then continued to drag client #1 out of the door of the pool area. Staff #1 neglected client #1 and client #2 when he made the decision to go to the pool with only one facility staff when two staff were required and staff #1 allowed/did not intervene when the YMCA staff physically held client #1 on the ground while he went to get his car. Additionally, Staff #1 put the clients into the car and transported them without any additional staff. This deficiency constitutes a Type A1 rule violation for serious abuse and neglect and must

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V 512	Continued From page 14 be corrected within 23 days. An administrative penalty of $2,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 512		