

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL018-102</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/12/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PINNACLE THERAPEUTIC SERVICES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2329 SPRINGS ROAD, NORTH EAST HICKORY, NC 28601</b>
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V 000	<p><b>INITIAL COMMENTS</b></p> <p>A complaint survey was completed on October 12, 2023. The complaint was substantiated (Intake # NC00207120). A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5100 Community Respite Services for Individuals of All Disability Groups.</p> <p>This facility is licensed for 6 and currently has a census of 0. The survey consisted of audits of 6 former clients.</p>	V 000		
V 512	<p><b>27D .0304 Client Rights - Harm, Abuse, Neglect</b></p> <p>10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION</p> <p>(a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66.</p> <p>(b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter.</p> <p>(c) Goods or services shall not be sold to or purchased from a client except through established governing body policy.</p> <p>(d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter.</p> <p>(e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.</p>	V 512		

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

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V 512	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, 3 of 6 audited staff (#1, #2, and the House Manager (HM)) abused and 4 of 6 audited staff (#1, #5, the HM, and the Licensee) neglected 6 of 6 audited Former Clients (FC) (#1, #2, #3, #4, #5, and #6). The findings are:</p> <p>Review on 9/20/23 of FC #1's record revealed: -Admission date: 7/13/23. -Discharge date: 9/12/23. -Age: 6 years old. -Diagnoses: Intellectual Development Disability (IDD) - unspecified, Borderline Intellectual Functioning, Oppositional Defiant Disorder (ODD), Attention Deficit Hyperactivity Disorder (ADHD) - impulsive type, Reactive Attachment Disorder, Exotropia of left eye, chronic idiopathic constipation, and combined urinary and fecal incontinence. -Psychological Evaluation completed by a previous provider dated 7/3/23 revealed: "Problems getting along with family, peers, purposeful urination on floor, fecal smearing, destructive play behavior, poor eye contact, stubborn, distrustful, suspicious, secretive, lying, sneaking ...temper tantrums, explosive episodes, acting violently, rule breaking, property destruction, cruelty to animals, angry, aggressive, moods change quickly, anxiety, learning problems, language problems, trouble concentrating, memory problems, disorganization, difficulty following directions, difficulty staying on task, distractible, difficulty listening, impulsiveness, bouts of excessive energy, always in motion, excessively fidgety,</p>	V 512		

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V 512	<p>Continued From page 2</p> <p>hyperactive and talkative."</p> <p>Review on 9/20/23 of FC #2's record revealed: -Admission date: 7/14/23. -Discharge date: 9/12/23. -Age: 13 years old. -Diagnoses: Major Depressive Disorder, ADHD, ODD, and Type 1 Diabetes. -Clinical Evaluation completed by a previous provider dated 5/30/23 revealed: "IVC (involuntarily commitment) due to mental health and behaviors...Current behavior: problems getting along with peers...secretive, lying, sneaking, frequent arguing, oppositional/defiant, temper tantrums, explosive episodes, acting violently, rule breaking, stealing, risk taking behavior...suicidal behaviors...depression/depressed mood/sadness...hallucinations...has trauma history ...impulsiveness..."</p> <p>Review on 9/20/23 of FC #3's record revealed: -Admission date: 7/24/23. -Discharge date: 9/12/23. -Age: 13 years old. -Diagnoses: Generalized Anxiety Disorder, Post-Traumatic Stress Disorder (PTSD), and ADHD. -Comprehensive Clinical Assessment (CCA) Addendum completed by a previous provider dated 7/17/23 revealed: "Recommendations: ... [Client #3] has exhibited severe difficulty maintaining safety in the community and home environment, resulting in frequent conflicts and need for current crisis stabilization admission due to lack of behavioral limits/structure...has poor boundaries...tends to develop fixations on certain staff/peers. She does report a history of sexual abuse and neglect...noted to have mood swings, poor self-esteem, anxiety, impulsivity and</p>	V 512		

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V 512	<p>Continued From page 3</p> <p>trauma-related symptoms ...."</p> <p>Review on 9/20/23 of FC #4's record revealed: -Admission date: 9/7/23. -Discharge date: 9/12/23. -Age: 9 years old. -Diagnoses of Major Depressive Disorder, PTSD, and ODD. -Treatment plan completed by a previous provider dated 5/10/23 revealed: "Client has a history of running away from facilities, self-harm and assaultive behavior."</p> <p>Review on 9/20/23 of FC #5's record revealed: -Admission date: 8/16/23. -Discharge date: 9/12/23. -Age: 14 years old. -Diagnoses: PTSD and Vaping Related Disorder. -CCA completed by a previous provider dated 8/16/23 revealed: "Client is pregnant, in middle school, parents were substance abusers, and needs to be in a structured environment."</p> <p>Review on 9/20/23 of FC #6's record revealed: -Admission date: 7/14/23. -Discharge date: 9/12/23. -Age: 16 years old. -Diagnoses: Myotonic Dystrophy recurrent - mild, Unspecified Trauma and Stressor Related Disorder, and Unspecified Anxiety Disorder. -CCA Addendum completed by a previous provider dated 7/13/23 revealed: "History of Present Illness...currently hospitalized for being AWOL (Absent Without Official Leave) for 11 days ...has a history of elopement, substance abuse, alcohol abuse, thoughts of suicide, self-harm, impulsive behaviors and sexual behavior with multiple people ...engages in sexual activity for money. ..."</p>	V 512		

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V 512	<p>Continued From page 4</p> <p>Interview on 9/13/23 with the county's Department of Social Services (DSS) Supervisor revealed: -All clients were removed from the facility on 9/12/23 by their respective DSS workers due to "significant concerns" of abuse and neglect.</p> <p>Review on 9/20/23 of Staff #1's personnel record revealed: -Date of hire: 6/28/23. -Direct Care Staff. -Adaptative De-escalation Alternatives (ADA) training completed: 6/27/23.</p> <p>Review on 9/20/23 of Staff #2's personnel record revealed: -Date of hire: 3/13/23. -Direct Care Staff. -ADA training completed: 6/26/23.</p> <p>Review on 9/20/23 of the HM's personnel record revealed: -Date of hire: 3/24/23. -ADA training completed: 4/5/23.</p> <p>Interview on 10/11/23 with the Licensee revealed: -He did not have a personnel record.</p> <p>Finding #1: Evidence Staff #1, Staff #2, and the HM abused FC#1 and FC#4.</p> <p>Review on 9/14/23 of an incident report dated 9/9/23 completed by Staff #2 regarding FC #4 revealed: -Report for "aggressive" and "destructive" behavior. -Cause of incident, FC #4 "was triggered when he was prompted to follow protocol." -FC #4 was prompted "to exit the office and allow staff to finish the task at hand before addressing</p>	V 512		

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V 512	<p>Continued From page 5</p> <p>his concern ...(FC#4) became frustrated, started using profanity and displayed physical aggression by kicking, hitting and spitting at staff ...To prevent [FC #4] from advancing in Staff personal space, I positioned myself and the [FC #4] in the corner. While in the corner I turned [FC #4] away from me to prevent the hitting, kicking and spitting on me. Staff was in this position for 4 minutes before releasing [FC #4] ...Staff walked [FC #4] to the living room area to avoid him from harming himself ...The assault and aggressive action lead to staff and [FC #4] on the floor ...[FC #4] continued to be verbally aggressive and began to reduce his physical aggression, staff then asked [FC #4] to go upstairs, [FC #4] eventually agreed and staff walked with [FC #4] upstairs ...Once [FC #4] entered the room he demonstrated violent actions by pushing and shoving his dresser and throwing his bookbag. [FC #4] demonstrated actions of self harm, by punching the window and banging his head on the head board ...Staff positioned near the window. This deterred [FC #4] from punching the window. [FC #4] then placed himself on his bed and began punching the headboard and hitting his head on the headboard ...[FC #4] violent actions reduced and he laid on his bed and continued to express himself verbally ....staff sat on the other bed as [FC #4] was no longer a threat to harming himself ..."</p> <p>Interview on 9/13/23 with the investigating DSS worker and review of photographs of FC #4 taken on 9/12/23 by the investigating DSS worker revealed:</p> <ul style="list-style-type: none"> <li>-Photograph #1 was of FC #4's neck and showed a reddened area just under his hairline on the back of his neck.</li> </ul> <p>Interview on 10/3/23 with FC #4 revealed:</p>	V 512		

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V 512	<p>Continued From page 6</p> <p>-Staff #2 restrained him and during this he "threw him on the ground, near the corner" by the front door.</p> <p>-Staff #2 "grabbed" his arms and "took" him upstairs.</p> <p>-When they were upstairs in his bedroom, Staff #2 "sat on top of me" on the bed.</p> <p>-Staff #2 left "red marks" on his neck and a bruise "near my hip area"</p> <p>-He didn't "feel like talking about it" further.</p> <p>Interview on 9/26/23 with FC #2 revealed:</p> <p>-"They (Staff #1 and HM) did it (shoving, hitting, dragging clients on the floor) all the time to [FC #1]."</p> <p>-"All the staff would do it, push him (FC #1), drag him, grab him by the shoulders until he was screaming...."</p> <p>-FC #1 had "a load" of bruises, staff (HM) would "blame" the bruising "on him (FC #1) being a little kid."</p> <p>-On 9/9/23, she saw Staff #2 "shoving him (FC #4) into the wall while he [FC #4] was screaming, 'please stop'...I saw him (Staff #2) shove him (FC #4) on the ground ...near the front door."</p> <p>-While FC #4 was on the floor, on his back, Staff #2 held FC #4 with half of one foot on FC #4's arm, and Staff #2's other foot was on FC #4's stomach.</p> <p>-FC #4 "kept promising he would calm down so [Staff #2] got off him. [FC #4] tried to go upstairs, [Staff #2] grabbed him and dragged him upstairs ...holding his (FC #4's) wrist up the entire time. ..."</p> <p>-Staff #1 "dragged him (FC #4) into the office ...he (FC #4) wouldn't do what [Staff #1] said ...you can't boss me around you're not my mom, [Staff #1] said you don't have a mom and she (Staff #1) dragged him into the office ...his arm and leg and started pulling him (FC #4) ...[Staff #1] threw him against the wall ...don't know which</p>	V 512		

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V 512	<p>Continued From page 7</p> <p>wall ...but you could hear it ...a really loud thump and clinging noise ...could hear them (Staff #1 and FC #4) screaming at each other ...."</p> <p>Interview on 9/29/23 with FC #3 revealed: -Staff #1 grabbed FC #1 " ...by his arms near his elbow, then picked him (FC #1) up. ..." -The HM "always be dragging [FC #1] ...by his arms ...telling him (FC #1) to go to his room for time out ...wouldn't go upstairs ...picked him (FC #1) up eventually, held him by their (FC #1) waist. ..." -FC #4 "got put in a restraint for spitting ...[FC #4] walked away and [Staff #2] just grabbed him (FC #4) for no reason ...by his shirt ...[FC #4] was screaming and spitting still. ..."</p> <p>Interview on 10/5/23 with FC #5 revealed: -"[FC #1] was often pulled on because he didn't listen." -Staff #1 pulled on FC #1. -On 9/9/23, FC #4 "had an attitude with [Staff #1], she pushed him against the wall. ..."</p> <p>Interview on 9/28/23 with FC #6 revealed: -"They grabbed [FC #1] by the arms and carried him upstairs when he was rowdy, arms would be red ...carried [FC #1] over the shoulder ...[HM, Staff #1] ...." -"[FC #4] was trying to run out the door and the staff [HM] grabbed him and swung him on the couch ..." -On 9/9/23, she "saw [FC #4] by the front door ...he was in the corner ...could tell he was scared, he was ducking and dodging ...[Staff #1 and Staff #2] were coming up on him in the corner, they were standing over him ...they were still arguing when she left (for work). ..."</p> <p>Interview on 9/25/23 with Staff #1 revealed:</p>	V 512		

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V 512	<p>Continued From page 8</p> <p>-On 9/9/23, FC #4 had an "outbreak ...he was heading to the door...[Staff #2] embraced him like a father. That's all that happened ...he was embracing him (FC #4) in between [FC #4] and the door ...held his hands ...hold them still ...he put his arms and legs around him (FC #4) ...took his (Staff #2) hand and put it on his (FC #4's) forehead, he was protecting himself and [FC #4] ...[FC #4] got his hand loose, went towards [Staff #2's] face, but knocked his hat off ...he tried to slide out of [Staff #2's] arms ...[Staff #2] picked him up ...lifted him up like you pick up a baby ...they went upstairs ...[FC #4] threw stuff around the room ...they ended up talking." -She denied treating any clients "roughly."</p> <p>Interview on 9/26/23 with Staff #2 revealed: -On 9/9/23, "around med (medication) time, client (FC #4) was upset because he didn't want to follow formalities ...he started shouting toward one of the staff members (Staff #1) ...there was verbiage between her (Staff #1) and the other client (FC #4) ...heard the volume of it ...don't recall what was being stated ...what alerted me was the level. I stepped in ...I wanted to make sure he (FC #4) didn't harm himself. He was kicking and spitting ...I put him (FC #4) in the corner to prevent physical contact, to prevent him from hitting on me. He started banging his head, I moved to the living room area...trying to get him to calm down ...to keep him from kicking and spitting ...his (FC #4's) arms were crossed in front of him ...grabbed him by the wrist and arms ...I tripped over him while he was kicking ...on the floor ...in the living room area ...After we fell I got ahold of one wrist and then the other and crossed them in front of his (FC #4's) body and I sat down in the chair ...he was sitting on the floor. I walked him upstairs ...made sure he wasn't able to hit me or anything ...he was shouting all kinds of</p>	V 512		

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V 512	<p>Continued From page 9</p> <p>verbiage ...I held both arms and my body with him (FC #4) to the side ...had his arms across his own body. I (Staff #2) was holding them at the wrist. Never had to pick him up ...to get him upstairs." -He was suspended after this incident for violating "house policy as far as hands on a client." -Had a training for de-escalating techniques and it "dealt with conversations ...saw him (FC #4) being aggressive towards me felt need to restrain so he didn't kick ..."</p> <p>Interview on 9/27/23 with the HM revealed: -On 9/11/23, when she came in at 8:00 a.m., she saw the incident report for FC #4 from Staff #2. -She "didn't know nothing about it (incident report) until I came in ...I saw paperwork on my desk ..." -She read the incident report and sent it to IRIS. -She denied ever threatening clients or having knowledge of other staff threatening clients.</p> <p>Interview on 9/20/23 with the Licensee revealed: -He was aware of the "episode" with FC #4 and Staff #2. -FC #4 was kicking and spitting and Staff #2 restrained him. -Staff #2 told him he restrained FC #4 "because of historical information he had read in his CCA ...he (Staff #2) didn't want him to bang his head." -The facility policy is to not use any physical restraints.</p> <p>Finding 2: Evidence the HM neglected FC #1's personal care needs.</p> <p>Interview on 9/13/23 with the investigating DSS worker revealed: -While at the facility for several hours on 9/12/23, she identified FC #1 had defecated in his pants. -When she checked FC #1, she identified he was not wearing diapers.</p>	V 512		

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V 512	<p>Continued From page 10</p> <ul style="list-style-type: none"> <li>-Requested the HM clean and change FC #1.</li> <li>-Was informed by the HM there were no diapers available for FC #1 to wear.</li> <li>-The HM stated she would not clean FC #1 and that FC #1 "was your (DSS) problem now.</li> <li>-She (DSS worker) cleaned up FC #1.</li> </ul> <p>Interview on 9/27/23 with the HM revealed:</p> <ul style="list-style-type: none"> <li>-FC #1 did soil his clothes at school, but he had a change of clothes.</li> <li>-He "had a pair (of shorts) at school that he changed in to and then he messed (defecated/urinated) them (shorts) a second time ...I went and picked him up that day because they (school) didn't have any more clothes. ..."</li> <li>-No knowledge of soiled clothes still in FC #1's backpack the next day.</li> </ul> <p>Finding #3: Evidence the Licensee neglected FC #2 and FC #6's supervision needs.</p> <p>Interview on 9/19/23 with FC #2's mom revealed:</p> <ul style="list-style-type: none"> <li>-The Licensee called her, date unknown, and said the client and FC #6 wanted to go to the mall.</li> <li>-She agreed with this thinking the staff were going to be with the client.</li> <li>-She found out later the Licensee dropped FC #2 and FC #6 off at that mall and left.</li> </ul> <p>Interview on 9/26/23 with FC #2 revealed:</p> <ul style="list-style-type: none"> <li>-She was dropped off at the mall with FC #6 without staff supervision, but she did not know the date.</li> </ul> <p>Interview on 9/28/23 with FC #6 revealed:</p> <ul style="list-style-type: none"> <li>-The Licensee dropped her and FC #2 off at the mall without staff supervision and they were picked up by Staff #2.</li> <li>-This happened one time and they were at the mall for approximately an hour.</li> </ul>	V 512		

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V 512	<p>Continued From page 11</p> <p>Interview on 9/28/23 with FC #6's DSS worker/guardian revealed: -She remembered the Licensee called her "and asked if she (FC #6) could go to the mall and I said 'Yes, as long as staff was there.'" -She was not aware the Licensee dropped FC #6 at the mall without staff supervision.</p> <p>Interview on 9/27/23 with Staff #3 revealed: -She was aware the Licensee dropped FC #2 and FC #6 off at the mall by themselves. -She "was supposed to go with the kids (FC #2 and FC #6) but they went behind my back and asked [Licensee]." -She was not sure of the date, but the clients were at the mall without staff supervision "maybe 30 minutes to an hour."</p> <p>Interview on 9/20/23 with the Licensee revealed: -He denied he dropped any clients at the mall without staff supervision.</p> <p>Finding #4: Evidence the Licensee neglected FC #6's supervision and treatment needs.</p> <p>Interview on 9/26/23 with FC #6 revealed: -The Licensee gave her a cell phone for her personal use. -The Licensee allowed her to access several social media websites. -She was still "in touch" with the Licensee through text messages (after her discharge). -Text messages with the Licensee included conversations about a laptop charger the Licensee needed and if the facility was going to re-open.</p> <p>Interview on 9/28/23 with FC #6's DSS worker/guardian revealed:</p>	V 512		

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V 512	<p>Continued From page 12</p> <ul style="list-style-type: none"> <li>-She was concerned the Licensee gave FC #6 a cell phone without her permission.</li> <li>-The Licensee "knew she (FC #6) was to not be on social media ...she (FC #6) has a history of inviting boys to the house (location prior to the facility) and buying drugs ...."</li> <li>-The Licensee allowed FC #6 access to social media websites.</li> <li>-FC #6 told her that the HM or the Licensee "monitored it."</li> <li>-FC #6 and the Licensee remained in contact with each other after FC #6 was discharged from the facility.</li> <li>-FC #6 said, "He's (Licensee) still texting me (after discharge)."</li> <li>-She got a "weird vibe" and asked FC #6 about the texts, FC #6 said 'nothing inappropriate had happened.'</li> </ul> <p>Interview on 9/20/23 with the Licensee revealed:</p> <ul style="list-style-type: none"> <li>-Let FC #6 use the facility's cellphone because she participated in after school activities.</li> </ul> <p>Finding #5: Evidence Staff #1, Staff #5, the HM, and the Licensee neglected FC #2 and FC #3's needs after an allegation of sexual abuse made by FC #2 against FC #3.</p> <p>Review on 9/20/23 of facility incident reports from 8/26/23 through 9/20/23 revealed:</p> <ul style="list-style-type: none"> <li>-No incident report regarding a sexual assault allegation from FC #2 against FC #3.</li> </ul> <p>Review on 9/20/23 of a facility "Grievance Form" dated 9/10/23 revealed:</p> <ul style="list-style-type: none"> <li>-A statement written by FC #2 "I was upstairs when [FC #3] started humping her bed. [FC #3] started pretending that she was doing a [social media video]. [FC #3] walked toward me and started touching me on my private parts. [FC #3]</li> </ul>	V 512		

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V 512	<p>Continued From page 13</p> <p>told me not to tell or she would tell them I touched her so I didn't say anything." -A statement written by FC #3 "[FC #2] said that I touched her inappropriate but I didn't." -"What are your thoughts on how this complaint should be resolved? Both clients need to be sat down and talked to find out what really happened upstairs" signed by Staff #1. -"Describe action(s) taken to resolve issue: First off when Management found out of incident with client [FC #3/FC #2] had allegations against each other, clients wrote statements on the incident on hand. Client was removed from each other upon @ (at) the time. Notified by HM ...Was the complaint resolved? (checked) yes ...Follow up needed, if so, what actions need to be taken?...Each client was removed to different rooms to resolve not contact. bed check from hourly to every 30 min (minutes)" signed by the HM. -Attached was a letter written by FC #2 " ...She [FC #3] walked over to me and said, 'Wanna do it?' and I said 'No don't even think about it.' [FC #3] tried to pull the blankets off me and I yanked them back up and said 'no.' [FC #3] again pulled the blankets down and I said 'I'm telling' ...I just layed there and let her finger me. [FC #3] got my make up brush and penetrated me with it. [FC #3] kept that up till 11:00 (p.m.) off and on. She got rougher and rougher till 12:00 (a.m.) at 1:00 (a.m.) she had me touch her till 1:15 (a.m.). ..."</p> <p>Review on 9/20/23 of a "Summary" signed by the Licensee and dated 9/14/23 revealed: -"Allegation of sexual abuse reported 9/10 (9/10/23) ...Additional steps of safety plan were taken. Bed checks were changed from every hour to thirty minutes. Clients were separated from their current room ...."</p>	V 512		

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V 512	<p>Continued From page 14</p> <p>Attempted review on 9/20/23 of room check documentation revealed there was no documentation maintained by the facility staff.</p> <p>Review on 9/20/23 of FC #2's record revealed: -No medical care or evaluation completed after an allegation of sexual assault and vaginal penetration with a make-up brush.</p> <p>Interview on 9/26/23 with FC #2 revealed: -On 9/9/23 between 9:30 pm and 1:00 am "She [FC #3] raped me. ..." -FC #3 was her roommate. -Reported the sexual assault on 9/10/23 to Staff #1 and Staff #5, "They didn't really believe me." -"Not true for any night" that staff did room checks, "that (sexual assault) could have never happened if they (staff) do hourly checks." -The HM called "mom that day (9/11/23) hyped up, she said if that really happened why did she (FC #2) wait until 3:00 p.m. the next day to tell her (HM). ..." -She was "scared" of FC #3. -She and FC #3 were not moved to separate bedrooms. -They continued to be roommates until all clients were removed from the facility on 9/12/23.</p> <p>Interview on 9/29/23 with FC #3 revealed: -FC #2 was her roommate. -FC #2 told Staff #1, "I touched her ...I don't even like girls ...Eww!" -FC #2 told a "big lie." -Never touched FC #2 sexually. -She and FC #2 had got into a fight in the past. -Staff #1 had her and FC #2 write a grievance against each other. -"No, we needed to ...never did ..." move to separate rooms.</p>	V 512		

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V 512	<p>Continued From page 15</p> <p>Interview on 10/5/23 with FC #5 revealed: -Never switched bedrooms with FC #2 or FC #3. -"Staff did not do room checks ...They said they did but I would've heard them."</p> <p>Interview on 9/28/23 with FC #6 revealed: -Never switched bedrooms with FC #2 or FC #3. -"If heard someone moving, they (staff) would be there (to do room checks)."</p> <p>Interview on 9/25/23 with Staff #1 revealed: -On 9/10/23 "at 3:00 (p.m.) FC #2 alleged FC # 3 "touched her on her boobs and down below (vagina) ...I said you wait till Sunday and this happened Saturday ...I said you don't wait 2 days to tell something like that. ..." -Had FC #2 and FC #3 write a grievance and spoke to both of them about the alleged sexual assault. -"I called them both in the office and said both 'tell me what happened' ...[FC 3] was humping the bed, then she touched my (FC #2's) boobs and private area (vagina) ...[FC #3] said [Staff #1] I swear I did not touch that B ...(b***h) ...[FC #2] said 'yes she was humping her bed' ...and then [FC #2] got quiet and wouldn't say nothing else." -FC #3 said "I was not humping my bed, and [FC #2] just likes me." -Reported the sexual assault grievance made by FC #2 to the HM on 9/11/23. -No knowledge of what happened after she reported the grievance to the HM.</p> <p>Interview on 9/25/23 with Staff #5 revealed: -Worked the weekend of 9/9/23 and 9/10/23 on first shift with Staff #1. -On 9/10/23, Sunday, FC #2 said to her '[FC #3] raped' her ...I told her she had to talk to [the Licensee] ..." -She didn't know who to believe, FC #2 and FC</p>	V 512		

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V 512	<p>Continued From page 16</p> <p>#3 were always "telling stories on each other ..." -FC #2 "really didn't tell me until that Monday (9/11/23) when she got off the bus (from school) ...she (FC #2) didn't give any more details ...asked her 'What was wrong with her,' she said '[FC #3] raped' her ...said 'Talk to [the Licensee] ..." -The Licensee was there on Monday, 9/11/23, and she walked FC #2 to the kitchen where the Licensee was at the time. -The Licensee and FC #2 then went into the office, she wasn't sure what happened after that, she "left." -Staff #1 had FC #2 and FC #3 write a grievance report and gave it to the HM.</p> <p>Interview on 9/27/23 with the HM revealed: -On 9/11/23, when she came in at 8:00 a.m., she saw the grievance reports for FC #2 and FC #3 from Staff #1. -She "didn't know nothing about it (grievance report) until I came in ...I saw paperwork on my desk ..." -One of the grievances were from FC #2 alleging she was sexually assaulted by FC #3, and the other grievance was from FC #3 denying the alleged sexual assault. -After she "read the grievance reports," FC #3 was moved into a bedroom with FC #5.</p> <p>Interview on 9/20/22 with the Licensee revealed: -On Sunday morning, 9/10/23, "once the grievance was made" was when he became aware of the sexual assault allegation made by FC #2 against FC #3. -"Got statements and started an internal investigation ...we were in the process of investigation ...then CPS (Child Protective Services) came in on 9/12 (9/12/23). ..." -We "changed bed checks from every hour to 30</p>	V 512		

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V 512	<p>Continued From page 17</p> <p>minutes ...[FC #3] moved in with [FC #6] ...on Monday 9/11 (9/11/23)."</p> <p>Finding #6: Evidence Staff #1 and the HM verbally abused FC #1, #2, #3, #4 #5, and #6.</p> <p>Interview on 9/26/23 with FC #2 revealed: -The HM said she (the client) "will be kicked out" if she said anything to her guardian about the sexual allegation against FC #3. -The Licensee and the HM said about her and FC #3, "If you can't get along, you're both going to have to leave."</p> <p>Interview on 9/29/23 with FC #3 revealed: -Staff #1 said to FC #1 she was "going to break every bone in his damn body ...he kept running and they was having a meeting and he kept running around and playing with his cars. She [Staff #1] sat him down ...'if you get up I'm going to break every bone in your body.'"</p> <p>Interview on 10/3/23 with FC #4 revealed: -Staff #1 said she would "put him [FC #1] and me in a body bag." -Staff #1 "yelled" at him and was "being rude" and said she would "break every bone" in his body.</p> <p>Interview on 10/5/23 with FC #5 revealed: -On 9/9/23, FC #4 "had an attitude with [Staff #1], she (Staff #1) pushed him (FC #4) against the wall, she (Staff #1) said she 'would send him (FC #4) to the hospital." -Staff said, "If they (clients) got in trouble, they (the clients) would go to the hospital." -The HM told her "If she (FC #5 didn't stop crying and stressing, she [FC #5] would kill her baby."</p> <p>Interview on 9/28/23 with FC #6 revealed: -Staff #1 "lost her temper too much ...she tried to</p>	V 512		

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V 512	<p>Continued From page 18</p> <p>take control ...'I'll beat your a** little boy (FC #1)' ...snippy to them (FC #1 and FC #4)."</p> <p>-She heard Staff #1 threaten FC #4 and said to him, 'I'm going to hit you back.'</p> <p>-The HM threatened FC #2 with "IVC [Involuntary Commitment] ...she said '3 strikes ...do you want 30 days or 30 seconds' ...as in you can be out (of the facility) in 30 seconds."</p> <p>Interview on 9/25/23 with Staff #1 revealed: -Denied stating to FC #1 she would break every bone in his body. -Denied making any threats to the clients.</p> <p>Interview on 9/27/23 with the HM revealed: -Denied she had threatened any clients and she had not heard any staff do this.</p> <p>Interview on 9/20/23 with the Licensee revealed: -He was aware of the allegation of Staff #1 making threats to "break every bone" in FC #1's body. -He had a "conversation" with Staff #1 and said, "Listen, I know you're just talking ...I know you're just messing around; you can't say that even if just playing ...." -He did not document anything regarding the allegation and his discussion with Staff #1.</p> <p>Review on 10/11/23 of the Plan of Protection dated 10/11/23 written by the Program Director/Qualified Professional revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care?" -Substantiated Abuse Citation- all staff cited for abuse have been terminated and will no longer have any interaction or access to any Pinnacle consumers. -Substantiated Neglect Citation - owner/CEO (Chief Executive Officer) [Licensee] will no longer</p>	V 512		

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V 512	<p>Continued From page 19</p> <p>have direct interactions or provide care to Pinnacle consumers.</p> <p>-All staff of Pinnacle will ensure continuation of care and communication between Pinnacle staff, consumers, and other agencies. Example: schools, jobs, social worker, parents, counselors, physicians, etc.</p> <p>-Consumers will be always supervised while on and off Pinnacle property.</p> <p>-All consumer individual support plans will be followed. This includes protecting consumer rights, but also following previously mandated restrictions. If it is explicitly stated in a consumer's plan that they are not to have access to social media or to a cell phone, Pinnacle will uphold these restrictions.</p> <p>Describe your plans to make sure the above happens?</p> <p>-Terminations of all 3 staff cited in the substantiated abuse case have been terminated by phone call from Program Director and/or Owner as of 12:30pm 10/11/2023. They will also be receiving termination letters detailing the grounds for termination in the mail.</p> <p>-A verbal disclosure of the substantiated neglect citation to the owner was also made at 12:15pm on 10/11/2023 to the Owner involved. A documented verbal counseling was also conducted during this phone call that covered neglect, appropriate supervision, and the reduction in involvement in consumer interaction. The owner agreed with these terms.</p> <p>-Pinnacle staff will follow the following procedure when consumers come home from school: Go through book bags and communication logs to ensure all homework is completed and all requirements are met. This will ensure open communication with the schools and continuation of care. All staff that are currently still employed with Pinnacle have already attended an intensive</p>	V 512		

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V 512	<p>Continued From page 20</p> <p>re-training led by the program director. This training included reviews of the following: Abuse, Neglect, and Exploitation; Critical Incident Definitions and Reporting Procedures; Active Supervision - training for this and new supervision log introduced are attached to this document; Positive Behavioral Supports. All consumers will have an individual support plan that is person-centered and includes as much information as possible from all members of the consumers care team. This would include their supervision requirements, as well as any restrictions put in place from their social worker. Staff will be trained on all of these for each consumer upon that consumer's admission and before the staff have any interaction with the consumer. This will ensure that the staff are well trained and have a working knowledge of how to best support and serve the consumer in a residential setting. This training will be documented so that all staff can and will be held accountable while themselves with that consumer. It also ensures the consumer's safety, should they be restricted from things like social mconducting edia or a cell phone."</p> <p>The facility served clients aged 6-16 years old with diagnoses including IDD, ADHD, ODD, PTSD, and Major Depressive Disorder. Client histories included trauma backgrounds and need for crisis stabilization and a structured environment. Staff #1 and the HM abused FC #1 by grabbing him by the arms and wrists, picking him up, and carrying him to another room to get him to comply with their requests. Staff #2 abused FC #4 by physically putting him in a corner, slamming him against the wall, throwing him to the ground, and grabbing his arms or wrists to force him to a different room or to go upstairs. These acts left bruises and red marks</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL018-102</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/12/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PINNACLE THERAPEUTIC SERVICES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2329 SPRINGS ROAD, NORTH EAST HICKORY, NC 28601</b>
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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 512	<p>Continued From page 21</p> <p>on FC #1 and FC #4. Photographs provided by DSS revealed a reddened area just under FC#4's hairline on the back of his neck. Staff #1 abused FC #4 by threatening him with physical harm. FC#1 has a history of urinary and fecal incontinence. The HM neglected FC#1's personal care needs by refusing to clean him and change his clothes after FC#1 defecated in his pants. FC#2 had a history of explosive episodes, temper tantrums, acting violently, rule breaking, stealing, impulsivity and risk taking. FC#6 had a history of elopement, substance abuse, alcohol abuse, self-harm and thoughts of suicide, impulsivity, and sexual behaviors for money. FC#6's DSS guardian identified that the Licensee was aware that FC#6 had a history of using social media to invite males to the home and purchase drugs. The Licensee neglected FC#2 and FC#6's supervision needs by dropping them at the mall without staff supervision. The Licensee provided a cell phone to FC#6 and allowed her to access social media websites without knowledge or permission from FC#6's legal guardian. The Licensee remained in contact with FC#6 using this cell phone after discharge from the facility. Staff #1 and Staff #5 neglected FC #2 when she reported FC #3 sexually assaulted her by failing to notify management of the allegation. Furthermore, there were not protective measures implemented after the allegation of sexual assault. Staff #1 and the HM abused the former clients by threatening physical harm towards FC#3 and FC#4. FC#1, #2, #3, #4, #5, and #6 witnessed the abuse and threats of violence and involuntary commitments to psychiatric facilities. FC#5 was a 14-year-old middle school student who was pregnant. The HM told FC #5 that if she didn't stop crying or stressing, that it would kill her baby. This deficiency constitutes a Type A1 rule violation for serious abuse and neglect and must</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL018-102</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/12/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PINNACLE THERAPEUTIC SERVICES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2329 SPRINGS ROAD, NORTH EAST HICKORY, NC 28601</b>
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V 512	Continued From page 22  be corrected within 23 days. An administrative penalty of \$5,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of \$500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 512		