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	MHL076-063	A. BUILDING: _____ B. WING _____	R 05/28/2024

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YOUTH UNLIMITED-SLANE HOME	2872 YOUTH UNLIMITED DRIVE SOPHIA, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on May 28, 2024. The complaint was substantiated (Intake #NC00216767). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for four and has a current census of one. The survey sample consisted of one current client and two former clients.	V 000		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have	V 109		

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V 109	Continued From page 1 met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record reviews and interviews, two of two audited former staff (FS #5 and Former Facility Director/Qualified Professional (FFD/QP)) failed to demonstrate knowledge, skills and abilities to meet the needs of clients. The findings are: Review on 5/14/24 of FS #5's personnel record revealed: -Date of hire was 5/9/23. -Hired as a Residential Counselor. -Termination date was 5/9/24. Review on 5/14/24 of the FFD/QP personnel's record revealed: -Date of hire was 1/25/21. -Hired as the Facility Director/Qualified Professional. -Termination date was 5/9/24. Review on 5/13/24 of the facility internal	V 109		

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V 109	Continued From page 2 investigation dated 5/7/24-5/8/24 revealed: -Staff #3 stated staff #1 and staff #2 reported the FFD/QP used profanity towards the kids. -Staff #2 stated that she heard the FFD/QP call former client #2 (FC #2) a "f****t". -Staff #2 stated the kids reported that the FFD/QP threatened them to not tell on what is going on or they will go to a Psychiatric Residential Treatment Facility (PRTF). -FC #2 stated that the FFD/QP used racial slurs towards client #1. -FC #2 stated that the FFD/QP has called him a "f****t." -Client #1 confirmed FC #2 reports of racial slurs. -Former client #3 (FC #3) stated that the FFD/QP used profanity a lot. -FC #3 stated he had heard the FFD/QP call FC #2 a "f****t". -FC #3 stated that the FFD/QP uses profanity a lot. -FC #3 reported hearing racial slurs towards client #1. -FC #3 stated that FS #5 and the FFD/QP made threats to keep the boys from reporting any allegations against them. Threats included being sent to a PRTF and this morning (5/7/24) that FS #5 called them all "little s*******s" for "snitching" on the former FD/QP. Interview on 5/28/24 with client #1 revealed: -The FFD/QP commonly called white people "crackers." -The FFD/QP yelled in the store "[FC #2] called me the N-Word." -The FFD/QP said things to embarrass us in front of other people and one another. -"He called [FC #2] a f****t." -"He showed me no respect and said, ' I do it because I am the adult here'."	V 109		

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V 109	Continued From page 3 Interview on 5/16/24 with FC #2 revealed: -The FFD/QP would call him a "f****t." -"[FFD/QP] said I was gonna burn in h**l because of my sexual preferences." -"[FFD/QP] would make comments or joke to the other clients to watch out that I may want to have sex with them in the home." -"[FFD/QP] walked through a store and said [client #1] called him the N- Word and was trying to publicly humiliate them." Interview on 5/16/24 with FC #3 revealed: -He witnessed FS #5 and the FFD/QP cursing at client #1 and FC #2. -"They worked together and they were friends." -"They told us they could get away with doing what they want and nobody was going to believe us." Interview on 5/15/24 with staff #1 revealed: -All of the clients reported to staff #2 and her of the verbal comments made towards them by the FFD/QP. -The clients reported incidents with the FFD/QP walking through a store and asked random black people, "What would you do if [client #1] called you the N-Word". -Clients reported the FFD/QP would call them "f****t". -FC #2 reported the FFD/QP discussed his sexual orientation with the other clients in the facility. -FC #2 stated the FFD/QP "would tell him because he is gay or goes both ways, he was going to h**l". -FC #3 shared that the FFD/QP stated to him and client #1 "FC #2 was gay and may try to assault you". -The FFD/QP made comment disclosing FC #2 medical diagnosis.	V 109		

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V 109	Continued From page 4 -"[FFD/QP] made some smart remarks- I'm not gonna eat after you or use the bathroom after you." Interview on 5/16/24 with staff #2 revealed: -She and staff #4 started working at the same time and all three clients shared incidents. -They stated the FFD/QP used inappropriate language. -They stated the FFD/QP made "f****t" comment towards FC #2. -The FFD/QP was very religious and pushed his religious views onto client #1 and FC #2. Interview on 5/28/24 with the Clinical Director and Interim Qualified Professional revealed: -"I was in the facility weekly to provide therapy and asked the clients how things were going and would reply 'fine'." -He was not aware these situations had occurred in the facility. -During the internal investigation clients stated they didn't want to get the "group home shut down." This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 109		
V 116	27G .0209 (A) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (a) Medication dispensing: (1) Medications shall be dispensed only on the written order of a physician or other practitioner licensed to prescribe. (2) Dispensing shall be restricted to registered pharmacists, physicians, or other health care practitioners authorized by law and registered	V 116		

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V 116	Continued From page 5 with the North Carolina Board of Pharmacy. If a permit to operate a pharmacy is Not required, a nurse or other designated person may assist a physician or other health care practitioner with dispensing so long as the final label, Container, and its contents are physically checked and approved by the authorized person prior to dispensing. (3) Methadone For take-home purposes may be supplied to a client of a methadone treatment service in a properly labeled container by a registered nurse employed by the service, pursuant to the requirements of 10 NCAC 26E .0306 SUPPLYING OF METHADONE IN TREATMENT PROGRAMS BY RN. Supplying of methadone is not considered dispensing. (4) Other than for emergency use, facilities shall not possess a stock of prescription legend drugs for the purpose of dispensing without hiring a pharmacist and obtaining a permit from the NC Board of Pharmacy. Physicians may keep a small locked supply of prescription drug samples. Samples shall be dispensed, packaged, and labeled in accordance with state law and this Rule. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure dispensing of medications was restricted to pharmacists, physicians or health care practitioners authorized by law and registered with the North Carolina Board of Pharmacy affecting one of one current client (#1) and two of two audited former clients (FC #2 and FC #3). The findings are:	V 116		

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V 116	Continued From page 6 Review on 5/13/24 of the facility internal investigation dated 5/7/24-5/8/24 revealed: -The Former Facility Director/Qualified Professional (FFD/QP) admitted to pre-dispensing medications for one weekend for all of the clients. -Staff #4 stated medications were pre-dispensed every weekend. Review on 5/13/24 of client #1's record revealed: -He was 16 years old. -Admission date was 7/25/23. -Diagnoses of Autism Spectrum Disorder, Disruptive Mood Dysregulation Disorder and Attention Deficit Hyperactivity Disorder (ADHD). Review on 5/13/24 and 5/20/24 of physician orders for client #1 revealed: -Order dated 2/16/24 for Bupropion 100 milligram (mg) (mood), two tablets every morning. -Order dated 8/11/23 for Guanfacine 4mg (explosive behaviors), take one tablet at bedtime; Mirtazapine 15mg (mood), take 1 tablet at bedtime and Quetiapine Fumarate 300mg (depression) take one tablet at bedtime. -Order dated 8/3/23 for Prazosin 1mg (anxiety), take 3 capsules at bedtime. Review on 5/13/24 of FC #2's record revealed: -He was 16 years old. -Admission date was 11/15/23. -Diagnoses of Post Traumatic Stress Disorder and Unspecified Mood Disorder. -Discharged date was 5/9/24. Review on 5/13/24 and 5/20/24 of physician orders for FC #2 revealed: -Order dated 4/17/24 for Acyclovir 80mg (antiviral), take one tablet two times a day for five	V 116		

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V 116	Continued From page 7	V 116		

days and Quetiapine Fumarate 300mg (depression), take one tablet at bedtime.
-Order dated 1/4/24 for Vyvanse 50mg (focus), take one capsule every day.

Review on 5/13/24 of FC #3's record revealed:
-He was 12 years old.
-Admission date was 3/25/24.
-Diagnosis of Oppositional Defiant Disorder.
-Discharged date was 5/10/24.

Review on 5/13/24 and 5/20/24 of physician orders for FC #3 revealed:
-Order dated 4/12/24 for Jornay 60mg (focus) take one tablet at bedtime
-Order dated 3/28/24 for Cetirizine 10mg (allergies), take one tablet as needed and Fluticasone Propionate 50 microgram (mcg) (allergies), place one spray in both nostrils daily as needed.

Interview on 5/16/24 with Former Staff #5 (FS #5) revealed:
-"I was not medication trained."
-I would give meds (medication) when the meds were left out for me to give to the boys (clients)."

Interview on 5/23/24 with the FFD/QP revealed:
-He placed medications in the pill containers.
-Each client had their own pill containers.
-He left the pill containers on the desk upstairs in the unlocked office.
-"I did that because no one knew how to get the medications out the blister packs, how to read the MAR and no one else was med (medication) trained. My hands were tied."

Interview on 5/13/24 and 5/28/24 with the Clinical Director/Interim Qualified Professional revealed:
-He was not aware that medication was

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V 116	Continued From page 8 pre-dispensed by the FFD/QP. -All staff received medication administration training. -He understood medications could not be dispensed prior to administration into pill containers. This deficiency is cross referenced into 10A NCAC .0209 Medication Requirements (V118) for a Type A1 violation and must be corrected within 23 days.	V 116		
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 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	V 118		

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V 118	Continued From page 9 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, interviews and observation the facility failed to keep the MARs current affecting one of one current client (#1) and two of two audited former clients (FC #2 and FC #3); failed to ensure one of two audited former staff (FS #5) was trained to administer medications and failed to ensure medications were available for administration affecting one of two audited former clients (FC #2). The findings are: Cross Reference: 10A NCAC 27G .0209 Medication Requirements (V116) Based on record reviews and interviews, the facility failed to ensure dispensing of medications was restricted to pharmacists, physicians or health care practitioners authorized by law and registered with the North Carolina Board of Pharmacy affecting one of one current client (#1) and two of two audited former clients (FC #2 and FC #3). Cross Reference: 10A NCAC 27G .0209 Medication Requirements (V120) Based on record reviews and interviews, the facility failed to ensure medications were in a securely locked container affecting one of one	V 118		

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V 118	Continued From page 10 current client (#1) and two of two audited former clients (FC #2 and FC #3). The following is evidence the facility failed to ensure the MAR was kept current. Review on 5/13/24 of the March 2024 MAR for client #1 revealed: -There was no documentation of medication administration for the following medication on 3/31. -Bupropion 100mg -Guanfacine 4mg -Mirtazapine 15mg -Quetiapine Fumarate 300mg -Prazosin 1mg Review on 5/13/24 of the March 2024 MAR for FC #2 revealed: -There was no documentation of medication administration for the following medication on 3/31. -Quetiapine Fumarate 300mg -Vyvanse 50mg Review on 5/13/24 of the March 2024 MAR for FC #3 revealed: -There was no documentation of medication administration for Jornay 60mg on 3/31. The following is evidence the facility failed to ensure a staff was trained in medication administration. Review on 5/14/24 of FS #5's personnel record revealed: -Date of hire was 5/9/23. -Hired as a Residential Counselor. -He did not have the medication administration training.	V 118		

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V 118	Continued From page 11 -Date of separation was 5/9/24. Interview on 5/16/24 with FS #5 revealed: -"I was not medication trained." -"I would give meds (medication) when the meds were left out for me to give to the boys." -"I did not sign the book (MARs) or know anything about that part." Interview on 5/23/24 with the Former Facility Director/Qualified Professional (FFD/QP) revealed: -He would initial on the MAR for staff administering medication on the weekend. -He initialed on the MARs as the newly hired weekend staff were trained a week after they started working. Interview on 5/28/24 with the Clinical Director/Interim Qualified Professional revealed: -All staff were trained in medication administration. -Not sure why the staff scheduled to work on 3/31/24 did not sign for medications. -He acknowledged staff failed to keep the MARs current for client #1, FC #2 and FC #3. The following is evidence the facility failed to ensure medications were available to administer. Review on 5/20/24 of the MARs from March 1, 2024 thru May 13, 2024 for FC #2 revealed: -Vyvanse 50 milligrams (focus), one capsule everyday. -Quetiapine Fumarate 30mg (depression), one tablet at bedtime. -The FFD/QP was the staff noted to have administered the medications for the reviewed sample.	V 118		

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V 118	Continued From page 12 Observation on 5/28/24 of the Clinical Director/Interim Qualified Professional call to the pharmacy revealed: -The pharmacy last filled a prescription of FC #2's Vyvanse 50mg was on 2/9/24. -The pharmacy technician confirmed that prescriptions were filled for the month of December 2023, January 2024 and February 2024. -The pharmacy technician stated no prescriptions were filled for the month of March or April 2024 for the medications Vyvanse 50mg. Interview on 5/16/24 with FC #2 revealed: -He was told by facility staff that his Department of Social Services Social Worker Legal Guardian (DSSSWLG) had to take him to the initial appointment with the new agency for the Vyvanse. -He went to two different emergency rooms for the medication. -The visits to the emergency room only prescribed a 30-day supply. -"The Vyvanse helped me to focus but I had not had that medication in almost a month." -"I was supposed to take two pills and only now took one." Interview on 5/23/24 with the FFD/QP revealed: -FC #2 was scheduled to have appointment with medication management agency closer to the facility. -The agency required the DSSSWLG to attend the initial appointment with FC #2. -The DSSSWLG never came to take FC #2 to the appointment. -FC #2 was taken to different emergency rooms on two occasions and was prescribed a 30-day supply at each visit. -He attempted several phone calls to the	V 118		

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V 118	Continued From page 13 DSSSWLG to remind them of the appointment with the medication management agency. Interview on 5/13/24 and 5/28/24 with the Clinical Director/Interim Qualified Professional revealed: -The initial appointment for medication management for FC #2 had to be done by the social DSSSWLG. -He was under the impression the DSSSWLG had completed the appointment with FC #2. -He was informed by the FFD/QP that FC #2 never completed the appointment. -He acknowledged the facility failed to ensure medications were available to administer to FC #2. Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician. Review on 5/28/24 of a Plan of Protection written by the Clinical Director/Interim Qualified Professional dated 5/28/24 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Staff in question were terminated upon investigation by agency. Individual pill containers were disposed of to prevent 'pre-dispensing'. All current clients were relocated due to immediate staffing needs. Describe your plans to make sure the above happens. Residential Coordinator will collect and review MARS each month. Staff will initial blister pack at time of dispensing to match MAR. Residential Coordinator will conduct random monthly med (medication) admin (administration) checks (currently no clients in this house). Program will implement a 'staff report card' which will be reviewed by the clinical director."	V 118		

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V 118	Continued From page 14 FC #2 had diagnoses of Post Traumatic Stress Disorder and Unspecified Mood Disorder. FC #2 was transported to the local emergency rooms on two occasions to fill prescriptions for Vyvanse 50mg. The pharmacy used by the facility had not filled any prescriptions for Vyvanse 50mg for the month of March or April 2024 for FC #2. The FFD/QP initialed on MARs for medications not available to FC #2. The FFD/QP also signed off on the MARs for all doses administered to all clients in the facility even though he was not the staff administering the medications. The FFD/QP initialed for administering medications for shifts that he did not work. Staff that worked the shift administered medications from pill containers that had medication dispensed by the FFD/QP. Medications were administered by FS #5 who was untrained in medication administration. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 118		
V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use;	V 120		

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V 120	Continued From page 15 (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure medications were in a securely locked container affecting one of one current client (#1) and two of two audited former clients (FC #2 and FC #3). The findings are: Review on 5/13/24 of client #1's record revealed: -Admission date was 7/25/23. -Diagnoses of Autism Spectrum Disorder, Disruptive Mood Dysregulation Disorder and Attention Deficit Hyperactivity Disorder. Review on 5/13/24 of FC #2's record revealed: -Admission date was 11/15/23. -Diagnoses of Post Traumatic Stress Disorder and Unspecified Mood Disorder. -Discharged date was 5/9/24. Review on 5/13/24 of FC #3's record revealed: -Admission date was 3/25/24. -Diagnosis of Oppositional Defiant Disorder. -Discharged date was 5/10/24. Interview on 5/16/24 with FC #3 revealed: -Medications were stored in the locked cabinet during the week. -On the weekends, "medications were in	V 120		

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V 120	Continued From page 16	V 120		

containers on the desk in pill containers for each of us."
-The door to the office was left open and not locked.

Interview on 5/15/24 with staff #1 revealed:
-She had been employed with the facility for 6 weeks and worked on the weekends.
-"Meds (medications in pill containers) were out" was the message relayed to staff #2 by former staff #5 (FS #5) during the shift exchange."
-She would administer medication to all the clients and staff #2 would witness.
-Confirmed that pill containers were left on the desk in the unlocked office the entire weekend for all clients.

Interview on 5/15/24 with staff #2 revealed:
-"[FFD/QP] would leave the medication in a pill container color coded for each client."
-The medication pill containers were left in the unlocked office on the desk.

Interview on 5/16/24 with FS #5 revealed:
-"I would give meds (medications) when the med were left out on the desk for me to give to the boys (clients)."
-The office was unlocked and the medication pill containers were left on the desk

Interview on 5/23/24 with the Former Facility Director/Qualified Professional (FFD/QP) revealed:
-Confirmed he placed medications in the pill containers left on the desk in the office.
-Each client had their own pill containers.
-"I did that because no one knew how to get the medications out the blister packs, how to read the MAR and no one else was med trained. My hands were tied."

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V 120	Continued From page 17 Interview on 5/28/24 with the Clinical Director/Interim Qualified Professional revealed: -All staff were trained in medication administration. -The medications were stored in the file cabinet locked in the upstairs office bathroom that remained locked. -"I'm really not sure why [FFD/QP] was putting the medication in the pill containers." This deficiency is cross referenced into 10A NCAC .0209 Medication Requirements (V118) for a Type A1 violation and must be corrected within 23 days.	V 120		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection 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.	V 132		

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V 132	Continued From page 18 d. Diversion of drugs belonging to a health care 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 allegations against health care personnel including injuries of unknown source and failed to ensure all alleged allegations were investigated. The findings are: Review on 5/13/24 of client #1's record revealed: -He was 16 years old. -Admission date was 7/25/23. -Diagnoses of Autism Spectrum Disorder, Disruptive Mood Dysregulation Disorder and Attention Deficit Hyperactivity Disorder.	V 132		

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V 132	Continued From page 19 Review on 5/14/24 of North Carolina Incident Response Improvement System (IRIS) revealed: -No level III IRIS for client #1's allegation of physical punishment. Review on 5/13/24 of the facility internal investigation report dated 5/7/24-5/8/24 revealed: -The local Department of Social Services reported allegations of "Concerns of corporal punishment ...". -The local Department of Social Services reported allegations of "Concerns that physical punishment was used." Interview on 5/28/24 with client #1 revealed: -Corporal punishment was used by Former Staff #5 (FS #5). -FS #5 made him complete excessive exercises as punishment. Interview on 5/28/24 with the Clinical Director/Interim Qualified Professional revealed: -He initiated the internal investigation after the local Department of Social Services visited the facility. -He was made aware of the allegations against FS #5 during the internal investigation. -He didn't view the allegation of physical punishment as abuse. - He acknowledged he failed to notify the HCPR of allegations against health care personnel.	V 132		
V 295	27G .1703 Residential Tx. Child/Adol - Req. for A P 10A NCAC 27G .1703 REQUIREMENTS FOR ASSOCIATE PROFESSIONALS (a) In addition to the qualified professional	V 295		

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V 295	Continued From page 20 specified in Rule .1702 of this Section, each facility shall have at least one full-time direct care staff who meets or exceeds the requirements of an associate professional as set forth in 10A NCAC 27G .0104(1). (b) The governing body responsible for each facility shall develop and implement written policies that specify the responsibilities of its associate professional(s). At a minimum these policies shall address the following: (1) management of the day to day day-to-day operations of the facility; (2) supervision of paraprofessionals regarding responsibilities related to the implementation of each child or adolescent's treatment plan; and (3) participation in service planning meetings. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to employ an Associate Professional (AP) who provided services to the group home on a full-time basis. The findings are: Interview on 5/28/24 with the Clinical Director/Interim Qualified Professional revealed: -The staff was recently terminated and the position had not been filled. -He was not aware the AP had to work full time. -He acknowledged the facility failed to employ an AP to the facility on a full-time basis. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 295		

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V 296	Continued From page 21	V 296		
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 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.	V 296		

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V 296	Continued From page 22 (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 record reviews and interviews the facility failed to ensure minimum number of direct care staff was present and awake affecting one of one current client (#1) and two of two audited former clients (FC #2 and FC #3). The findings are: Review of facility records on 5/13/24 revealed: -The group home was licensed as a 1700 Residential Treatment Staff Secure for Children or Adolescents facility. -The license capacity was for four children or adolescents. Interview on 5/28/24 with client #1 revealed: -"The agency was short staff and a lot of times the Former Facility Director/Qualified Professional (FFD/QP) worked by himself." -Former Staff #5 (FS #5) would work two days a week on 3rd shift with the FFD/QP. -There was no other staff working the day he and fellow clients had to sit in the van. Interview on 5/16/24 with FC #2 revealed: -There was no other staff that worked the day he	V 296		

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V 296	Continued From page 23 and fellow clients were left on the van. Interview on 5/23/24 with the FFD/QP revealed: -He had been employed with the agency for 3 years and four months. -He was hired as the Facility Director/Qualified Professional. -His duties entailed creating work schedules for staff, supervising staff, maintain operations of the home and other duties related to caring for the clients. -He worked all shifts 1st shift 8am-4pm, 2nd shift 2pm-10pm and 3rd shift 10pm-8pm. -Confirmed that he worked alone on the date clients were left unsupervised in the van. -He couldn't recall if staff was scheduled to be off that day or did not show up to work their shift. -He acknowledged the facility failed to ensure minimum number of direct care staff was present and awake.	V 296		
V 366	27G .0603 Incident Response Requirements 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;	V 366		

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V 366	Continued From page 24 (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing 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	V 366		

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V 366	Continued From page 25 determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall 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.	V 366		

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V 366	Continued From page 26	V 366		

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 II and level III incidents. The findings are:

Review on 5/13/24 of client #1's record revealed:
-He was 16 years old.
-Admission date was 7/25/23.
-Diagnoses of Autism Spectrum Disorder, Disruptive Mood Dysregulation Disorder and Attention Deficit Hyperactivity Disorder.

Review on 5/13/24 of the facility's incident report log revealed:
-There was no incident report documented of the alleged excessive physical punishment of exercises toward client #1.

Review on 5/14/24 of the North Carolina Incident Response Improvement System (IRIS) revealed:
-There was no IRIS report, risk/cause analysis or documentation to support submission of written preliminary findings of fact to the Local Management Entity (LME)/Managed Care Organization (MCO) within 5 working days for the allegation of physical punishment.

Review on 5/14/24 of Former Staff #5's (FS #5) record revealed:
-Hire date of 5/9/23.
-He was hired as a Residential Counselor.
-Date of termination was 5/9/24.

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V 366	Continued From page 27 Interview on 5/28/24 with the Clinical Director/Interim Qualified Professional revealed: -He was responsible for completing, submitting into IRIS and responding to incident reports. -"I did not think I needed to complete an IRIS on this incident as one was completed on the other staff situation." -"I completed the IRIS on the incident that I was made aware of during the internal investigation." -He acknowledged he failed to implement policies governing their response to level II and level III 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	V 367		

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V 367	Continued From page 28	V 367		

cause of the incident; and
(6) other individuals or authorities notified or responding.
(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:
(1) the provider has reason to believe that information provided in the report may be 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

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V 367	Continued From page 29 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 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 review and interview, the facility failed to notify the LME/MCO (local management entity/managed care organization) within 72 hours of an incident. The findings are: Review on 5/14/24 of the IRIS (Incident Response Improvement System) revealed no Level II or Level II incident reports from February 28, 2024 to May 13, 2024. Review on 5/13/24 of an internal investigation dated 5/7/24-5/8/24 by the facility revealed: -"[Former Staff #5 (FS #5)] sent [staff #2] a text that she won't have a job." "[Client #1] reports that [FS #5] assigned physical	V 367		

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V 367	Continued From page 30 punishment but that [Former Facility Director/Qualified Professional (FFD/QP)] didn't stop it." -"Reports that [FS #5] and [FFD/QP] made threats to keep them quiet. Threats included being sent to a Psychiatric Residential Treatment Facility and this morning (5/7/24) that [FS #5] call them all "little s*******s" for "snitching" on [FFD/QP]." Interview on 5/28/24 with the Clinical Director/Interim Qualified Professional revealed: -He completed the IRIS report based on his internal investigation. -He was not aware that he needed to complete an IRIS report regarding the situation with FS #5. -He acknowledged that he failed to notify the LME/MCO within 72 hours of the incident.	V 367		
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	V 512		

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V 512	Continued From page 31 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 two of two audited former staff (FS #5 and Former Facility Director/Qualified Professional) abused and neglected one of one current client (#1) and two of two audited former clients (FC #2 and FC #3) to abuse and neglect. The findings are: Review on 5/14/24 of the FFD/QP personnel's record revealed: -Hire date of 1/25/21. -Was hired as the Facility Director. -Terminated on 5/9/24. Review on 5/14/24 of Former Staff #5's (FS #5) record revealed: -Hire date of 5/9/23. -He was hired as a Residential Counselor. -Date of termination was 5/9/24. Review on 5/13/24 of client #1's record revealed: -He was 16 years old. -Admission date was 7/25/23. -Diagnoses of Autism Spectrum Disorder, Disruptive Mood Dysregulation Disorder and Attention Deficit Hyperactivity Disorder. Review on 5/13/24 of FC #2's record revealed: -He was 16 years old. -Admission date was 11/15/23.	V 512		

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V 512	Continued From page 32 -Diagnoses of Post Traumatic Stress Disorder and Unspecified Mood Disorder. -Discharged date was 5/9/24. Review on 5/13/24 of FC #3's record revealed: -He was 12 years old. -Admission date was 3/25/24. -Diagnosis of Oppositional Defiant Disorder. -Discharged date was 5/10/24. Review on 5/13/24 of the facility's internal investigation dated 5/7/24-5/8/24 revealed: -"Concerns from Department of Social Services of [FFD/QP] taking the kids (clients) to a dinner event and left the kids in the van for around 3 hours, corporal punishment and cursing at the children." -"[FS #5] admits that [FFD/QP] came to [restaurant] in [a city approximately 45 minutes away] last Thursday and kept the kids in the van." Review on 5/14/24 of the Incident Response Improvement System (IRIS) report dated 5/9/24 revealed: -"An allegation of neglect and abuse was made to the Child Protective Services..." -The allegations were "[FFD/QP] took the kids to a dinner event and left the kids in the car for around 3 hours. Concerns of corporal punishment, cussing at the children and racial slurs being used against the children ..." -"The results of the investigation conducted by the facility indicate that there are serious problems with two employees. These concerns include a fear or physical abuse, threats to clients, derogatory language towards clients, physical neglect ..." Interview on 5/28/24 with client #1 revealed: -"There were staff that were mentally and	V 512		

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physically abusive."
-"The main staff was [FFD/QP]."
-The FFD/QP threw drinks in cups at him when the FFD/QP was upset.
-"One time [FFD/QP] woke me up to clean the entire kitchen because I forgot to wipe off the stove."
-"One time [FFD/QP] thought I bucked up (flexed my shoulders) at another staff and [FFD/QP] pushed my head into the wall."
-The FFD/QP left him and his fellow peers unsupervised on the van for two hours and 30 minutes. "It was [FS #5] graduation dinner and we were not invited inside."
-THE FFD/QP rolled down the windows and didn't provide any food or snacks.
-"[FFD/QP] came and checked on us after the first 45 minutes and that was it."
-"We arrived at 6:30pm and left at 9pm."
-"[FFD/QP] had us eat dinner at 5:30pm before we left the house (facility). He said he would take us out when we left the event and he lied."
-They arrived home and were told to go to bed and they were offered no snack or anything.
-He witnessed the FFD/QP "name calling" FC #2.

Interview on 5/15/24 with FC #2 revealed:
-He witnessed the FFD/QP hit client #1 when he did something wrong. He witnessed FFD/QP hit client #1 in the face with his fist.
-He saw the FFD/QP throw cups of drinks at client #1 when angry.
-"[FFD/QP] and [FS #5] were friends."
-The FFD/QP wanted to attend FS #5's graduation dinner party and left him and his housemates unsupervised in the van for 2 hours.
-The windows were rolled down and they were told they could open the van door.
-"He came and checked on us once in the 2 hours."

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V 512	Continued From page 34 Interview on 5/16/24 with FC #3 revealed: -He witnessed FS #5 and the FFD/QP mistreat client #1 and FC #2 by "instigating" a fight between client #1 and FC #2. -"[FS #5] and [FFD/QP] would curse at client #1 and FC #2." -FS #5 and the FFD/QP were friends and most of the time worked together. -"They told us they could get away with doing what they want, nobody was going to believe us." -The FFD/QP left them unsupervised on the van for 2 hours to attend a graduation party. -The graduation party was in a city approximately 45 minutes away. -"We left the facility about 6:30pm and was there until 9:15pm." -The FFD/QP came out to check on them once, which was 30 minutes after being there. -The FFD/QP didn't allow them to eat once they returned to the facility. Interview on 5/15/24 with staff #1 revealed: -The clients reported the incident 2 weeks ago. -Clients reported FS #5 had a graduation party that the FFD/QP attended leaving them in the van. -The clients reported they were sitting in the van for 3 hours. -Client reported that the FFD/QP told them they would get ice cream on the way home. -Client #1 reported that he got in trouble and FS #5 made him do push-ups. -Client #1 reported FS #5 stepped on his back as he was coming up from doing the push up. -Client #1 reported he requested Ibuprofen and the FFD/QP denied his request. -"I cannot recall the date [client #1] said the incident happened but said was during the week."	V 512		

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V 512	Continued From page 35 Interview on 5/15/24 with staff #2 revealed: -The clients shared two Sundays ago about the van incident with the FFD/QP. -Client stated the FFD/QP attended a graduation dinner for a college buddy. -"They said they were supposed to go in but were left on the van for 2-3 hours with windows cracked with no water or food." -"[FFD/QP] told them if they get hot to open the door and let some fresh air in and then close the door back." Interview on 5/16/24 with staff #3 revealed: -The clients reported that the FFD/QP instigated a fight between client #1 and FC #2. -The clients reported there were physical altercations with the FFD/QP and client #1. -The clients reported that the FFD/QP hit client #1 on the back of his head and caused client #1 to hit his forehead on the desk. -The clients were not able to provide any dates or times the events occurred. Interview on 5/16/24 with FS #5 revealed: -He and the FFD/QP had been friends for 5-6 years. -He graduated and had a celebration that the FFD/QP wanted to attend. -The FFD/QP did attend his celebration and the clients were left unsupervised in the van. -The FFD/QP checked on the clients 2-3 times. -"I was celebrating my accomplishment and wasn't really thinking to have [FFD/QP] have the boys (clients) come in." -There was an allegation that he used exercise as punishment with client #1. -"[Client #1] said he would rather go outside and run. I did not let him run long." -He denied witnessing the FFD/QP physically hit any of the clients.	V 512		

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V 512	Continued From page 36 Interview on 5/23/24 with the FFD/QP revealed: -Admitted to leaving the clients on the van unsupervised to attend FS #5's graduation dinner. -Admitted to leaving the clients on the van for no more than 30 minutes, not 2-3 hours. -"We left the group home around 7pm and returned back to group home at 9pm." -He did not use profanity or make any sexual comments towards any clients. -He denied throwing cups filled with drink on client #1, hitting client #1 in the face with his fist or hitting client #1 causing him to hit his forehead on the desk. -He denied calling FC #2 a f****t. -"[FC #2] made mention that he did not like the word f****t and they had a conversation to acknowledge his thoughts and feeling." Interview on 5/13/24 and 5/28/24 with the Clinical Director/Interim Qualified Professional revealed: -FS #5 and the FFD/QP were immediately terminated upon completion of his internal investigation. -He acknowledged that FS #5 and the FFD/QP were friends. -"I'm not sure what more can be done as orientation, training and monthly meetings are completed with all staff." -He does plan to do some additional training to address professionalism with the staff. -He plans to implement a staff report card and give to client to report their interactions with staff. Review on 5/28/24 of a Plan of Protection written by the Clinical Director/Interim Qualified Professional dated 5/28/24 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Staff in question were terminated upon investigation by	V 512		

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V 512	Continued From page 37 agency. Individual pill containers were disposed of to prevent 'pre-dispensing. All current clients were relocated due to immediate staffing needs. Describe your plans to make sure the above happens. Residential Coordinator will collect and review MARS each month. Staff will initial blister pack at time of dispensing to match MAR. Residential Coordinator will conduct random monthly med (medication) admin (administration) checks (currently no clients in this house). Program will implement a 'staff report card' which will be reviewed by the clinical director." Client #1, FC #2 and FC #3 ranged in age range from 12 to 16 years old and were diagnosed with Autism Spectrum Disorder, Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder, Post Traumatic Stress Disorder, Unspecified Mood Disorder and Oppositional Defiant Disorder. On 5/2/24, the FFD/QP transported the three clients to a graduation dinner for FS #5 in another city. The clients were left alone and unsupervised in the van for 2 1/2 hours with no water or food while the FFD/QP attended FS #5's graduation dinner. On other occasions the FFD/QP and FS #5 physically and verbally abused the clients by throwing cups filled with drink, hitting clients with fist, using push-up exercises for punishment, and calling a client a f****t. This deficiency constitutes a Type A1 rule violation for serious abuse and neglect and must be corrected within 23 days.	V 512		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS	V 736		

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V 736	Continued From page 38 (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observation on 5/13/24 at approximately 2:36pm of the facility revealed: -Upon driving up to the home grass in the front yard 9 inches high. -Front porch area- Two living room couches covered in dust and spider webs. -Side door entrance- Area- Various pairs of shoes (tennis shoes, boots, slides, etc.) dirty and covered in spider webs sitting on stairs. -Odor of musk throughout the entire home. -Kitchen area-floor vent rusted. -Empty bedroom- Random shoes and clothing on floor in room and closet of empty room. -Client #1 room- bed unmade, clothing, shoes, and papers on the floor in room and the closet. -Living room area- Blind slates, some were bent and some broken. -Bathrooms- Both tubs had soap scum, floors dirty and sticky and toilet lids stained with urine. Interview on 5/13/24 with the Clinical Director/Interim Qualified Professional revealed: -The grass had not been cut as maintenance was awaiting part to repair lawn mower. -Things are replaced and repaired in the home and clients would damage the items. -Clients were to keep their rooms clean and organized. -He acknowledged the facility needed to maintain the home in a safe, clean, attractive and orderly	V 736		

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V 736	Continued From page 39 manner. This deficiency has been cited three times since the original cite on October 25, 2022 and must be corrected within 30 days.	V 736		