STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL090-225	A. BUILDING: _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INWARD BOUND	4825 FARMVIEW DRIVE MONROE, NC 28110

(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 A complaint survey was completed on 5/29/24. The complaint was substantiated (intake #NC 00215795). Deficiencies were cited. The facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. The facility is licensed for 4 and currently has a census of 2. The survey sample consisted of audits of 2 current clients and 4 former clients.	V 000		
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. 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	V 132		

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V 132	Continued From page 1 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 report allegations of abuse and harm to the Health Care Personnel Registry (HCPR), failed to complete the investigation of alleged acts as required, and failed to protect the client from harm pending an investigation. The findings are: Review on 5/2/24 of the facility's Internal Investigation on 1/11/24 incident dated 1/16/24 revealed: -"The following is a summary of the incident and the actions taken by me, [Associate Professional (AP)]. On Thursday January 11th, we arrived back at the house (facility) from a group activity. [Former	V 132		

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V 132	Continued From page 2 Client (FC) #2] asked to speak to me (AP) about his [gaming system], which I had confiscated earlier in the week due to his poor academic performance and refusal to do his chores. I explained to him the reasons why he was not getting his [gaming system] back and reminded him of the expectations and rules of the household. [FC #2] became upset at the comments that I made about him and began to be disrespectful by using profanity, talking back, and turning his back to me as I spoke to him. As I was speaking to him, he walked away to his room. He proceeded to use profanity, kick his dresser, and stomp on the floor. I followed him to calm him and was talking to him to try and get him to calm down. He kicked his dresser and began banging his head against the wall. I concluded that he was trying to harm himself, so I attempted to place him in a therapeutic hold." Review on 4/30/24 of FC #2's record revealed: -Admit date 4/13/23; -Age 16 years; -Discharge date 2/23/24; -Diagnoses Disruptive Mood Dysregulation Disorder; Attention Deficit Hyperactivity Disorder; Post Traumatic Stress Disorder, Unspecified; Disruptive, Impulse Control and Conduct Disorder. Record review on 4/30/24 of the AP's personnel record revealed: -Hired 9/29/23; -Job title Associate Professional. Review on 5/10/24 and 5/13/24 of the facility's January 2024 staff schedule revealed: - The AP finished work shift (2nd shift, 2:45pm-9:30pm) on date of incident, 1/11/24; - The AP worked alternating weekends and was	V 132		

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V 132	Continued From page 3	V 132		

scheduled off on weekend following incident (1/12/24-1/14/24);
-There was a scheduled holiday 1/15/24;
-The AP reported he worked 1/16/24-1/17/24;
-Worked part-time in the facility, 1/24/24-1/31/24;
-Resumed regular scheduled shift(s) beginning 2/1/24.

Review on 5/2/24 of the facility's Internal Incident Report dated 1/16/24 revealed:
-Date of incident 1/11/24;
-FC #2 was interviewed by the Owner/Licensee 1/16/24 and concluded that he "didn't get any wrongdoing by the staff;"
-The Program Manager (PM) and the Qualified Professional (QP) were made aware of FC #2's allegation against the AP by FC #2's school principal on 1/16/24.

Review on 5/2/24 of facility's records revealed:
-No documentation to support that systems were put in place to protect FC #2 after the 1/11/24 incident involving the AP and during an investigation on 1/16/24;
-No HCPR notification for the alleged abuse incident dated 1/11/24 which involved the AP.

Interview on 5/2/24 with FC #2 revealed:
-The AP "was cussing at me, being all aggressive;"
-After the AP "slammed me, he got on top of me and was holding me down using his hands on my wrists;"
-The AP "had his hand on my neck" and afterward had marks/bruises;
-"[PM and QP] saw the marks" on 1/12/24;
-The AP "didn't acknowledge" (the marks/bruises) after the incident on 1/11/12.

Review of emails sent on 4/29/24 and 5/8/24 from

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the Owner/Licensee to the Department of Health Service Regulation (DHSR) surveyor revealed:
-"When I was doing my investigation, he (FC #2) told me there was no incident. He stated he was in the wrong;"
-"The pictures were taken the night of the incident. [PM] stated at 10am that next morning when he arrived at [QP's] home, they were checking [FC #2] out. They did not take pictures. They state that he (the PM) put the flashlight on his phone to look at him (FC #2) closer, to ensure that he (the PM) wasn't missing anything. At this point staff was extremely paranoid about any occurrences with consumers, because of the Department of Social Services (DSS) workers approach toward the agency. They wanted to make sure they didn't miss anything. [FC #2] had superficial marks at the base of his neck. There was no skin broken. Staff asked [FC #2] if he needed medical attention, and he said that he was fine. Staff monitored client throughout the night.
[AP] was removed from the schedule for the weekend he was suppose to work (1/19/24-1/21/24). When he returned he was put in our [sister facility] until the investigation was complete."

Interview on 4/30/24 and 5/29/24 with the Owner/Licensee revealed:
-Had "knowledge of the incident with staff (AP) and [FC #2]" on 1/11/24;
-"Staff (AP) engaged (FC #2)" and put FC #2 in "therapeutic hold;"
-Denied allegations of staff performing inappropriate hold;
-FC #2 "was taken to [QP's] house the day after the incident;"
-"Pictures were taken because staff were being extra careful due to the restraint because of

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V 132	Continued From page 5 previous investigations (by the Department of Social Services);" -FC #2 "never reported abuse" by the AP; -Was made aware that FC #2 alleged abuse by FC #2's school principal 1/16/24; -DSS investigated the incident on 1/17/24 and the DSS social worker alleged abuse; -Did not believe allegations warranted making a report since FC #2 "never accused" the AP of abuse; -Was aware of HCPR reporting process; -"Doing this work since 1999. If something happens, I am going to address it and take care of it. I haven't done this (work) this long and not do it right. Kids (clients) are usually swinging during restraint; there was not one kid that had restraint that needed medical treatment;" -"Interviewed all the kids and first question to them was, 'do you feel safe?';" -Was the person responsible for completing the HCPR reports.	V 132		
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	V 296		

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V 296	Continued From page 6 (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. (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 observations, record reviews and interviews, the facility failed to ensure the staffing ratio of two staff for up to four adolescents. The	V 296		

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V 296	Continued From page 7 findings are: Observation on 4/29/24 and 4/30/24 at approximately 2:20 pm in the facility revealed: -The Associate Professional (AP) arrived at the facility alone with clients #1 and #6. Record review on 4/29/24 for Client #1 revealed: -Admit date 4/5/24; -Age 11 years; -Diagnosis Oppositional Defiant Disorder; -No documentation in treatment plan that allowed transportation by one staff (alone) when there was more than one client. Record review on 4/30/24 for Client #6 revealed: -Admit date 4/15/24; -Age 10 years; -Diagnosis Attention Deficit Hyperactivity Disorder; Post-Traumatic Stress Disorder; Oppositional Defiant Disorder; -No documentation in treatment plan that allowed transportation by one staff (alone) when there was more than one client. Interview on 4/29/24 with Client #1 revealed: -"One staff at night (3rd shift-9pm-9am), one staff on second shift (evening-3pm-9pm), 1-2 (staff) on first shift (morning-9am-3pm) ...normally one." Interview on 4/29/24 with Client #6 revealed: -"Two people at night, one person takes us to school;" -"Usually one staff when I come home from school until bedtime ...sometimes it's two." Interview on 5/2/24 with FC #2 revealed: -"One staff for each shift; went to bed, one staff; woke up, one staff, by dinner in evening, one staff."	V 296		

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V 296	Continued From page 8 Interview on 4/30/24 with the AP revealed: -Provided transportation for FC #1 and #6; -Picked up clients at facility to transport to school and "take clients to appointments;" -"There are two on staff at all times." Interview on 4/30/24 with the Program Manager (PM) revealed: -There were "always two people on staff." Interview on 4/30/24 with the Qualified Professional (QP) revealed: -"Two staff work each shift;" -"There should always be two staff working each shift."	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; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements	V 366		

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set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and

(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.

(b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.

(c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by:

(1) immediately securing the client record by:

(A) obtaining the client record;

(B) making a photocopy;

(C) certifying the copy's completeness; and

(D) transferring the copy to an internal review team;

(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:

(A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;

(B) gather other information needed;

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V 366	Continued From page 10 (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 11 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement written policies governing their response to level ll and lll incidents. The findings are: Review on 5/2/24 of the facility's Internal Investigation of 1/11/24 incident dated 1/16/24 revealed: -"The following is a summary of the incident and the actions taken by me, [Associate Professional (AP)]. On Thursday January 11th, we arrived back at the house (facility) from a group activity. [Former Client (FC) #2] asked to speak to me (AP) about his [gaming system], which I had confiscated earlier in the week due to his poor academic performance and refusal to do his chores. I explained to him the reasons why he was not getting his [gaming system] back and reminded him of the expectations and rules of the household. [FC #2] became upset at the comments that I made about him and began to be disrespectful by using profanity, talking back, and turning his back to me as I spoke to him. As I was speaking to him, he walked away to his room. He proceeded to use profanity, kick his dresser, and stomp on the floor. I followed him to calm him and was talking to him to try and get him to calm down. He kicked his dresser and began banging his head against the wall. I concluded that he was trying to harm himself, so I attempted to place him in a therapeutic hold. -No Incident Response Improvement System (IRIS) report, Risk Cause/Analysis, or documentation to support submission of the written preliminary findings of fact to the Local Management Entity/Managed Care Organization	V 366		

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V 366	Continued From page 12 (LME/MCO) within 5 working days for incident on 1/11/24." Interview on 4/30/24 and 5/29/24 with the Owner/Licensee revealed: -Picture was taken on 1/11/24 and marks on FC #2's neck were acknowledged; -Was responsible for entering incident reports for the facility; -Did not feel the 1/11/24 incident warranted report as FC#2 denied harm, "he (FC #2) told me it (the incident) was nothing", during internal interview on 1/16/24,"[FC #2] stated that he had no issues;" -"My investigation didn't get any wrongdoing by the staff;" -No documentation was available regarding the cause of the incident, corrective measures, measures to prevent similar incidents from occurring and the person(s) to be responsible for implementation of corrective and preventive measures; -Requested documentation regarding reports, but was not provided by exit date.	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	V 367		

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be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:
(1) reporting provider contact and identification information;
(2) client identification information;
(3) type of incident;
(4) description of incident;
(5) status of the effort to determine the cause of the incident; and
(6) other individuals or authorities notified or responding.
(b) Category A and B providers shall explain any 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

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V 367	Continued From page 14 Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to submit a level II incident report in the Incident Response Improvement System (IRIS) and notify the Local Management	V 367		

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V 367	Continued From page 15 Entity/Managed Care Organization (LME/MCO) responsible within 72 hours of becoming aware of the incident with Former Client (FC) #2 and the Associate Professional (AP) on 1/11/24. The findings are: Review on 5/2/24 of the facility's Internal Investigation of 1/11/24 incident dated 1/16/24 revealed: -"The following is a summary of the incident and the actions taken by me, [AP]. On Thursday January 11th, we arrived back at the house (facility) from a group activity. [FC #2] asked to speak to me (the AP) about his [gaming system], which I had confiscated earlier in the week due to his poor academic performance and refusal to do his chores. I explained to him the reasons why he was not getting his [gaming system] back and reminded him of the expectations and rules of the household. [FC #2] became upset at the comments that I made about him and began to be disrespectful by using profanity, talking back, and turning his back to me as I spoke to him. As I was speaking to him, he walked away to his room. He proceeded to use profanity, kick his dresser, and stomp on the floor. I followed him to calm him and was talking to him to try and get him to calm down. He kicked his dresser and began banging his head against the wall. I concluded that he was trying to harm himself, so I attempted to place him in a therapeutic hold." Review on 4/30/24 of FC #2's record revealed: -Admit date 4/13/23; -Age 16 years; -Diagnoses Disruptive Mood Dysregulation Disorder; Attention Deficit Hyperactivity Disorder; Post Traumatic Stress Disorder, Unspecified; Disruptive, Impulse Control and Conduct	V 367		

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V 367	Continued From page 16 Disorder. Review on 4/30/24 of the IRIS from 1/05/2024 - 1/31/2024 revealed: -Facility made no report in IRIS; -No documentation was submitted in IRIS, to the LME/MCO, or Health Care Personnel Registry (HCPR) for incident on 1/11/24. Interview on 4/30/24 with the Qualified Professional revealed: -"I write up incident reports when I observe;" -"[Program Manager] and [Owner/Licensee] check to see if incident reports are done." Interview on 05/29/2024 with the Owner/Licensee revealed: -Was the person responsible for submitting reports to IRIS; -Was aware of the IRIS reporting process; -"I am aware of the process for reporting ...I've done it before;" -Did not do an IRIS report because FC #2 did not report abuse by the AP.	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	V 512		

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V 512	Continued From page 17 necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews 1 of 1 Associate Professional (AP) abused 1 of 4 former clients (FC #2) and 2 of 2 Qualified Professionals (Qualified Professional (QP) and Program Manager (PM)) failed to protect 1 of 4 former clients (FC #2) from harm. The findings are: Review on 4/30/24 of FC #2's record revealed: -Admit date 4/13/23; -Age 16 years; -Discharged 2/23/24; -Diagnoses Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder, Post Traumatic Stress Disorder, Unspecified Disruptive, Impulse Control and Conduct Disorder. Review on 4/30/24 and 5/9/24 of photo received from the facility Owner/Licensee revealed: -FC #2 standing upright, dressed in a red, sleeveless tank/shirt with rounded neckline; -Neck area in view with improved visibility when	V 512		

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photo was enlarged;
-Three linear (outline of three fingers) marks/discolorations on the upper, mid neck (approximately 1.0-2.5 inches by 0.1-0.3 inches wide), and brownish red mark on lower neck (approximately 1.5-2.0 inches by 0.1-0.3 inches wide).

Review on 4/30/24 of the AP's personnel record revealed:
-Hire date 9/29/23;
-Trainings included De-escalation Techniques in Residential Services and Evidence-Based Protective Interventions (EBPI), 1/27/24.

Review on 4/30/24 of the PM's personnel record revealed:
-Hire date 7/1/17;
-Trainings included De-escalation Techniques in Residential Services and EBPI, 1/27/24;
-Family relationship with the Owner/Licensee (uncle).

Review on 4/30/24 of the QP's personnel record revealed:
-Hire date 6/10/13;
-Trainings included De-escalation Techniques in Residential Services and EBPI, 1/27/24;
-Family relationship with the Owner/Licensee (uncle).

Review on 5/2/24 of the facility Internal Investigation on 1/11/24 incident dated 1/16/24 revealed:
-"The following is a summary of the incident and the actions taken by me, [AP].
On Thursday January 11th, we arrived back at the house (facility) from a group activity. [FC #2] asked to speak to me (the AP) about his [gaming system], which I had confiscated earlier in the

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week due to his poor academic performance and refusal to do his chores. I explained to him the reasons why he was not getting his [gaming system] back and reminded him of the expectations and rules of the household. [FC #2] became upset at the comments that I made about him and began to be disrespectful by using profanity, talking back, and turning his back to me as I spoke to him.
As I was speaking to him, he walked away to his room. He proceeded to use profanity, kick his dresser, and stomp on the floor. I followed him to calm him and was talking to him to try and get him to calm down. He kicked his dresser and began banging his head against the wall. I concluded that he was trying to harm himself, so I attempted to place him in a therapeutic hold. [FC #2] started to attack me once I came closer. [FC #2] was irate and inconsolable and would not listen to reason. He began swinging wildly as I attempted to coral his arms. In the process of restraint [FC #2] dropped to the floor to maneuver out of the hold. I went down with him, while on the floor he was kicking and trying to headbutt me. I was finally able to get leverage, and I held him until he eventually calmed down. I released him after about 5- 10 minutes. Once [FC #2] was calm, I instructed him to clean his room and told him he could leave his room once he was finished. Dinner was ready to be served. Once [FC #2] finished cleaning, he ate with the rest of the boys. After dinner, he asked to speak with me before my shift ended, and I agreed. We went into his room, and I recorded the conversation where he admitted that his behavior was not okay. I informed the Qualified Professional of the encounter, and he instructed me to make sure 3rd shift staff monitor him throughout the night. [PM] told me to take pictures of [FC #2] after the incident to document that there were no visible

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injuries. I also asked [FC #2] if he was hurt in any way. [PM] said that he would be in (come into the facility) to see him (FC #2) in the morning.
After the restraint (the AP) took a picture of the client (FC #2) so that he (the AP) had documented evidence of no injuries. The agency has had a few instances where there were false allegations made against staff. The staff member (the AP) wanted to make sure that he is protecting himself from that.
-[QP]: The next day [PM] brought [FC #2] to my house to meet up with me prior to taking [FC #2] to his therapy appointment that he got scheduled for that day. The purpose of the meet up was to make sure staff did a proper restraint and to assist and help [FC #2] get back in the proper head space. I, [QP] had a better relationship with [FC #2], Moreso than the other staff. [FC #2] tends to respond better to me for some reason. After we met up [PM] took [FC #2] with him. They hung out the rest of the day and just talked about things. They discussed what happened and how things can be different in the future.
-[PM]: He (the PM) informed [Owner/Licensee] of the restraint and how [FC #2] was doing mentally after having been restrained. [FC #2] went to school (1/16/24), and later that day the principal called and stated that he has to make a DSS (Department of Social Services) report based on a letter that [FC #2] wrote. In the letter he (FC #2) talked about the restraint. The principal stated that when he talked to [FC #2], he (FC #2) said it was nothing, but the Principal said he had to make the report anyway.
-[Owner/Licensee]: I (the Owner/Licensee) interviewed [FC #2] and asked him about the restraint. He (FC #2) told me that it was nothing. He stated that he got mad and blacked out and started hitting his head on the wall. He also said that the only reason he wrote the stuff down, is

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because that is the way he vents his frustrations. This is one of his coping mechanisms. [FC #2] stated that his friend so the writing in his book and snatched it away and took it to the principal. He (FC #2) said it was nothing. He stated that was how he was feeling at the time he wrote it. He said he is good and there was nothing going on out the way. I asked him does he felt safe in the group home. He said he does feel safe. He also said that he doesn't like [AP] and [PM] because they don't listen to him. They like to tell him what to do and won't allow him to give his opinion. [FC #2] feels that they (the AP and PM) are both too strict. When asked; I said other than that, how are things going. He said everything else is good.
-DSS (Department of Social Services) involvement: [DSS Social Worker (SW)]: [DSS SW] came out to the group home to interview consumers. She talked to all the consumers (who were present in the facility) in the home. She said everything is in order. No consumer in the home has any issues. No one has reported anything out of order. She said that [FC #2] recanted, and he is good. [DSS SW] says that there will be a follow-up and the case will be closed.
- (The Owner/Licensee) spoke with [DSS SW] on January 24
She (the DSS SW) stated that [FC #2] recanted. At this point I closed my investigation.
...Conclusion:
[FC #2] stated that he had no issues. He felt that he was in the wrong and was having a bad day. He said he doesn't understand why he can't get visits like the other kids.
My investigation didn't get any wrongdoing by the staff (the AP, facility staff).
- Dated January 24, 2024"

Interview on 5/2/24 with FC #2 revealed:

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V 512	Continued From page 22 -"He (the AP) put me in therapeutic hold (1/11/24) because he said I was flipping over things and that was a lie"; -Was "trying to walk away (from the AP) in the living room (of the facility) and he wouldn't let me; then I go in my room, and he follows me to my room. He was cussing at me and stuff, being all aggressive;" -"Restrained when he (the AP) grabbed me, and I pushed him away;" -"After he (the AP) slammed me, he got on top of me and was holding me down using his hands on my wrists;" -"I was on the floor, and it ended with him telling me to stop moving and eventually I stopped moving. He had his hands on my neck. Afterward, I had marks on my neck;" -Marks/bruises remained "for a couple of days;" -"[PM and QP] saw the marks;" -"[AP] never acknowledged the marks;" -Did not feel safe in the facility. "I felt like he (the AP) was going to do it again." Interview on 4/30/24 and 5/28/24 with the AP revealed: -Picked up FC #2 (from school) and "realized he didn't have a good day at school and asked if he took medication; [FC #2] did not take meds that day;" -FC #2 had issues and had altercation with peer and the AP talked to him, FC #2 was "defiant;" -FC #2 "was upset at the house;" -The AP had "confiscated" FC #2's gaming system due to "sagging pants ... also for academics...had too much time with [gaming device];" -FC #2 had gaming system earlier in the week while out of school and asked when he would get it back, the AP told him he "had to earn it back;" -"Insisted on eye contact when talking" to FC #2;	V 512		

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V 512	Continued From page 23 -FC #2 "was defiant and went to bedroom without permission, started damaging property;" -"You have to ask permission" to leave one room and go into another room/space in the facility; -Went into FC #2's bedroom to de-escalate the situation; -FC #2 kicked dresser and was cursing; -"Stood up again (from seated position) and "put him in a hold and told him he couldn't get up until he calmed down;" -Took pictures 'immediately after hold' and there were "no wounds, marks or bruising;" -Has had "defying moments" and verbal disagreements with FC #2 about once monthly; -"I grabbed him (FC #2) by his shoulders (demonstrated holding the upper forearm muscle) and pinned him down. We were standing face to face, I grabbed him and put him to the ground. I had his arms; I put my body weight on him. I told him to calm down. When he got up, he was calm;" -"The therapeutic hold was an approved hold. It was a hold used in class" (EBPI Training class); -Did not recall putting his hands on FC #2's neck; -Marks may have occurred as result of the AP's "arm may have gone through sleeves" of FC #2's tank top/shirt; -"No first aid was needed;" -Was not aware of marks/bruise until the DSS Social Worker mentioned and picture was enlarged (around 1/17/24); -"I recorded the conversation where he (FC #2) admitted that his behavior was not okay;" -Admitted that FC #2 was not aware the conversation was being recorded. Interview and observation on 4/30/24 at 2:11pm and 5/28/24 at 11:24am with the PM revealed: -Was not present 1/11/24, "informed later that evening 9-9:30pm;"	V 512		

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V 512	Continued From page 24 -"[QP] reached out to me (1/12/24), his thought was let's see if [FC #2] is ok, make sure he doesn't need any attention;" -"Reached out to upper management (the Owner/Licensee) and they asked me to get him (FC #2) to an emergency therapy;" -Transported FC #2 from facility to the QP's home the following morning (1/12/24), so the QP could "put eyes on [FC #2];" -Confirmed FC #2 "had a mark on lower part of neck (demonstrated by touching the lower area of his own neck);" -Observed marks described as "minor cat scratch" at the base of FC #2's neck; -Tried getting FC #2 into therapy, "he missed school because of trying to get to therapy appointment ...wasn't able to get him to appointment;" -First aid was offered, "I guess he said no, that was my understanding; I don't typically document first aid;" -FC #2 mentioned that he and the AP "were not seeing eye to eye;" -Was already looking to move the AP to a sister facility; -The AP was off schedule for the weekend after the incident; -The AP "came to work for a few days (not sure of days/dates). Then was switched" to sister facility; -"I know there were a few times when he had to pick up [FC #2] and the other clients from school, or come to the home (facility), so we had to have him on the schedule;" -"Looking back, we could have done things a lot better." Interview on 4/30/24 and 5/28/24 with the QP revealed: -Was not present for incident on 1/11/24; -Received pictures the night of 1/11/24 "showing	V 512		

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marks on his (FC #2's) neck ...think they were obtained during the restraint;"
-"It was early morning when I got word from [PM];"
-Observed FC #2 the following morning;
-The PM transported FC #2 to the QP's personal home, "to meet up with me prior to taking [FC #2] to his therapy appointment that he got scheduled for that day. The purpose of the meet up was to make sure staff did a proper restraint and to assist and help [FC #2] get back in the proper head space;"
-"[PM] took [FC #2] with him. They hung out the rest of the day and just talked about things. They discussed what happened and how things can be better;"
-"[FC #2] did not go to school (1/12/24) because he was not in the right head space, not because of scratches on his neck;"
-Did not provide first aid, "would like to think he received first aid;"
-The AP worked alternating weekends and was not scheduled to work weekend after the incident (1/12/24-1/14/24);
-The AP returned to work in the facility the following week;
-"I came back and worked Tuesday (1/16/24) and Wednesday (1/17/24) before they pushed me to the other house (sister facility), until they figure out protocol;"

Interview on 5/28/24 with the EBPI Instructor revealed:
-Provided Nonviolent Crisis Intervention (NCI) Training and EBPI Training;
-Had provided in person instruction in NCI and EBPI for a total of 15 years;
-" I don't train to do none of that" (hold technique the AP described in interview on 4/30/24 and 5/28/24);

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL090-225	A. BUILDING: _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INWARD BOUND	4825 FARMVIEW DRIVE MONROE, NC 28110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	Continued From page 26 -"If a client goes down to the ground, they (staff) are to release them (client) and step back. There is also control and limited control escort hold, but they (staff) are taught to release and take a step back if client goes to the ground." Review on 5/29/24 of the Plan of Protection dated 5/29/24 and signed by the Owner/Licensee revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? The staff will be re-trained in de-escalation methods as well at EBPI restraint training. Staff will follow the implemented crisis plan put in place by the team and consumer. In the event of that a consumer is experiencing a mental health crisis that may result in a restraint, the staff will get assistance by the on-call staff to aid in the de-escalation. The Director ([Owner/Licensee]) will increase his supervision with staff to ensure he understands the best way to keep an incident from escalating to a point of physical intervention. I will be doing weekly observations of the shifts involving staff. In the event of an allegation of abuse the Director ([Owner/Licensee]) will do an internal investigation within 24 hours of the incident, and remove staff from the schedule until it has been deemed that the matter has been handled satisfactorily to meet the needs of the consumer involved. -Describe your plans to make sure the above happens. I will have the instructor schedule a training no later than Friday the 31st. My supervision have already begun and will continue until we deem that staff is in full compliance of the standards. I will document my supervisions with staff."	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 512	Continued From page 27 The facility served clients with diagnoses of Disruptive Mood Dysregulation Disorder; Attention Deficit Hyperactivity Disorder; Post Traumatic Stress Disorder, Unspecified; Disruptive, Impulse Control and Conduct Disorder, and ranging in ages 10-16 years old. On 1/11/24, the AP refused to return a gaming system that had been confiscated due to his poor academic performance and failure to complete chores and FC #2 became angry. FC #2 went to his room, kicked his dresser, and began banging his head against the wall. The AP went to FC #2's bedroom and while attempting to implement a restraint, FC#2 dropped to the floor and the AP went down to the floor with him, and held him for 5-10 minutes until he calmed down. After the incident the AP contacted the PM and was instructed to take a picture of FC#2. The AP sent the picture of FC #2 to the PM and the PM forwarded the picture to the QP on 1/11/24. The picture of FC#2 showed 3 linear marks on his neck. On 1/12/24, the PM took FC #2 to the QP's home to look the client over, the QP and AP acknowledged that there were marks on FC #2's neck, and no first aid was provided. The QP and the PM failed to protect FC #2 from harm by not removing the AP from work schedule and allowing the AP to continue to work with FC #2. This deficiency constitutes a Type A1 rule violation for serious abuse and must be corrected within 23 days.	V 512		