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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on 9-20-24. The complaint was substantiated (intake # NC00220451, and #NC00220649). 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 4 and currently has a census of 2. The survey sample consisted of audits of 1 former client.	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 review and interviews 1 of 1 Qualified Professionals (QP) and 1 of 1 Associate Professionals (AP) failed to demonstrate the knowledge, skills, and abilities required by the population served. The findings are:: Cross Reference: G.S. 131E-256 (G) Health Care Personnel Registry-Notification, Allegation and Protections (Tag V132) Based on record reviews and interviews, the facility failed to report all allegations against health care personnel, failed to complete an internal investigation and failed to protect a client during the investigation process affecting 1 of 1 audited staff (staff #2). Cross Reference: 10A NCAC 27G .1704 Minimum Staffing Requirements (Tag 296). Based on record review and interviews, the facility failed to ensure the minimum staffing ratio of two staff for up to 4 adolescents.	V 109		

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Cross Reference: 10A NCAC 27G .0603 Incident Response Requirements For Category A And B Providers (Tag 366). Based on record review and interview the facility failed to implement written policies governing their response to level I and II incidents.

Cross Reference: 10A NCAC 27G .0604 Incident Reporting Requirements For Category A And B Providers (Tag 367). Based on record review and interviews, the facility failed to report II incidents to the Local Management Entity/Managed Care Organization (LME/MCO) responsible for the catchment area where services were provided within 72 hours of becoming aware of the incident.

Cross Reference: 10A NCAC 27D .0101 Policy On Rights Restrictions And Interventions (Tag 500). Based on record reviews and interview, the facility failed to ensure all incidents of alleged abuse was reported to the County Department of Social Services (DSS).

Review on 9-3-24 of the AP's record revealed:
-Date of hire: 2-9-21.
-Job title: Associate Professional.

Review on 9-18-24 of the QP's record revealed:
-Date of hire: 2-9-21.
-Job title: Qualified Professional.

Interview on 8-26-24 with the AP revealed:
-"Responsible for oversight of the daily management of the home including making sure home is staffed properly. Supervision of the staff, shift coverage, training staff, Attends Child and Family Team meeting, Person Centered Plan meetings, making sure the residents have what they need. Make sure they are safe, Payroll,

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review notes and documentation, making sure the home is operating within the rules and regulations."

Interview on 8-26-24 with the QP revealed:
-"I'm basically responsible for everything. Works with the AP to oversee day to day operations. I do more of the operations, more clinical, quality management. Staffing, cover shifts, staffing, training, Yeah, everything basically."

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

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

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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 all allegations against health care personnel, failed to complete an internal investigation and failed to protect a client during the investigation process affecting 1 of 1 audited staff (staff #2). The findings are:

Review on 8-26-24 of the Incident Response Improvement System revealed:
-No documentation of reporting to HCPR of staff #2 failing to protect FC #3 from incident occuring on 8-6-24.

Interview on 9-3-24 with staff #2 revealed:
-"I was outside doing a parameter check around the house (8-6-24). I usually do that every morning before the guys (clients) get up to make sure that no one has dropped any contraband around the house. I was about half way around the house and I heard a commotion so I ran back around to the front. I opened the door and stood in the doorway to see what was going on and [Former Staff (FS #1)] was on the floor straddling [Former Client)#3 (FC #3]. [FC #3] was on the floor on his back. [FS #1] was standing over him, like one leg was at his waist level on one side of his body and the other leg was on the opposite side and he (FS #1) had his (FC #3's) arms pinned. He (FS #1) was holding them (FC #3's arms) so [FC #3] couldn't move."
-"Yeah, he (FC #3) was still trying to move, he

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was mad he was cursing (can't remember exact words) trying to get out of the hold. No, I didn't go in. He (FS#1) had it under control, I didn't think he needed my help. I stepped out in the yard and called [Qualified Professional (QP)] to let her know what was going on."
-"No, FC #3 did not ask him for help."
-"I'm not exactly sure how long he (FS #1) had him (FC #3) in the hold, I would say at least 10 minutes maybe...he (FC #3) finally calmed down. [FS #1] got up and stood back and he (FC #3) laid there (on the floor) for a minute or two then he got up and went to his room."
-"No, I didn't see [FS #1] put his knee around his (FC #3's) neck. At first, when I first opened the door he (FS #1) was trying to get him (FC #3) in the hold and he (FC #3) was struggling/he was fighting. [FS #1] got his arms and crossed them across his chest but he (FC #3) was fighting that. That's when he (FS #1) got his arms by his side and he was able to hold him there until he calmed down."
-Denied seeing FS #1 hit FC #3.
-Denied hearing FS #1 curse at or call FC #3 names.
-"Yeah, I mean if there is two staff and we have to put someone in a restraint or hold we use two people. When I got there, he already had him in the hold. I never came in the house. I stood in the doorway the whole time. I was on the phone with [QP]."

Interview on 8-26-24 and 9-16-24 with the QP revealed:
-"Staff #2 called me and told me [FC #3] attacked [FS #1] and he (FS #1) put him in a restraint. When I got there everything was over.
-No documentation of an internal investigation. "Yeah I talked to them (the clients and the staff) and asked them what happened. No, I didn't

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V 132	Continued From page 6 write anything down." -"There was no abuse, it was a therapeutic hold, he (FC #3) was attacking a staff and he (FS #1) put him in a therapeutic hold. No, [Staff #2] was not suspended, he was not involved in the hold." -Staff #2 continued to work with FC #3 until FC #3's discharge (8-7-24). -Did not report to HCPR, staff #2's failure to protect FC #3 from abuse from FS #1 on 8-6-24. -No internal investigation documenting staff #2's failure to protect FC #3 from abuse on 8-6-24. Interview on 9-3-24 and 9-10-24 with the Non-Violent Intervention (NCI plus) trainer revealed: -NCI instructor for over 24 years. -Provided the NCI training for staff #2. -"Ideally a therapeutic hold should be used with 2 staff." -"No, definitely not. I do not teach that (a hold that would require someone's knee in a clients neck or chest area)." -"They (staff are trained that they are not to use their legs except in a block, like to block a kick." -"No, ma'am, I do not teach any hold where someone would cross someone's arms across their chest. We didn't even teach that when we were doing the old [Previously used training]." -"What we (NCI trainers) teach is when someone falls to the floor you are suppose to release and back away from them." This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies Of Qualified Professionals And Associate Professionals (Tag 109) for a standard level deficiency and must be corrected within 60 days.	V 132		

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V 296	Continued From page 7	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 8 (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 review and interviews, the facility failed to ensure the minimum staffing ratio of two staff for up to 4 adolescents. The findings are: Review on 9-3-24 of former client #3's record revealed: -Date of admission: 8-17-23. -Date of discharge: 8-7-24. -Age: 15. -Diagnoses: Attention Deficit Hyperactivity Disorder Combined Type; Unspecified Trauma and Stressor Related Disorder. Interview on 8-26-24 with client #1 revealed: -"Before that (the 8-6-24 incident between former client #3 and former staff #1) there was one staff on third shift. Since that happened there has been 2 staff on third shift. Yeah usually two staff (on the other shifts), sometimes one when someone calls out or does not show up." Interview on 9-3-24 with former client #2 revealed: -"Usually only one staff working on shift.	V 296		

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Sometimes two but most of the time just one."

Interview on 9-3-24 with former staff #1 revealed:
-"Always two staff per shift."

Interview on 9-3-24 with staff #2 revealed:
-"Two staff work on each shift."

Interview on 8-26-24 and 9-16-24 with the Associate Professional (AP) revealed:
-"There's really not a schedule per se. Everyone just works when and where they are needed to make sure the shifts are covered."
-"Shifts are 11pm to 8 or 9am, first shift is 8am to 3pm and second shift is 3pm to 11pm. 2 staff per shift. [QP] and myself are responsible for making sure the shifts are covered."
-"There have been some shifts where we only had one staff working. Yeah there have been some shifts when we have not been in ratio."
- "We actually are applying for a waiver to see if we can get an exemption from the staffing rule due to being so short staffed. We have been short staff for a while, a long time (unknown date)."
-"No (she has not completed the waiver application as of 9-16-24). I have spoken to someone (unnamed) but we have not completed the application yet (for the waiver), I am going to be contacting [Division of Health Service Regulations Section Chief to inquire about that waiver."
-"Sometimes staff will forget to clock in. I try to catch that (missing staff clock in's) when I check the payroll. I check it (payroll) at least twice a month before I submit the payroll if I know someone forgot to clock in I add them (to the payroll) then."
-"Yes the payroll information that I provided on September 12, 2024 is correct. That is what has

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V 296	Continued From page 10 been paid through the most current pay period (payroll approved and paid through September 15. 2024)." Review on 9-12-24 of the facility's payroll entries for the period of July 1, 2024 to September 8, 2024 revealed: -For period of July 1, 2024 to September 8, 2024 there were five out of twenty one 7am to 3pm (first) with one or no staff clocked in during first shift hours.. -For period of July 1, 2024 to September 8, 2024 there were eleven out of seventy four 3pm to 11pm (second) shifts with one or no staff clocked in during second shift hours. - For period of July 1, 2024 to September 8, 2024 there were twenty four out of seventy three 11pm to 8am (third) shifts with one or no staff clocked in during third shift hours. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies Of Qualified Professionals And Associate Professionals (Tag 109) for a standard level deficiency and must be corrected within 60 days.	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	V 366		

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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 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

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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;
(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;

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V 366	Continued From page 13 (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record review and interview the facility failed to implement written policies governing their response to level I and II incidents. The findings are: Attempted review on 8-26-24 of the facility's Level I and II incident reports for May 1, 2024 to 8-26-24 revealed: -No Level I or II incident reports for period requested. -No Risk/Cause/Analysis for former client (FC #3) increase in aggressive behaviors, stealing and possessing contraband beginning in February or March 2024. Review on 8-26-24 of the Incident Response Improvement System for May 1, 2024 to August 26, 2024 revealed: -Incident dated 8-6-24: "Provider 08/06/2024 The member (Former Client #3 (FC)) was on restriction due to going into two (2) staff member's (staff #3 and unnamed staff) pocketbooks and became angry when the staff (Former Staff #1 (FS)) advised that he (FC #3) could not have his MP3 player. The member turned over the office desk on the staff and they began to tussle. The staff member was able to get away from the staff and while the staff placed	V 366		

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him in a therapeutic hold they (FC #3 and FS #1) tussled, and, both report to have injuries but neither of them have seen a docotor (doctor) at this time."

Interview on 8-26-24, 9-3-24 and 9-12-24 with the Qualified Professional (QP) revealed:
-Former client #3 (FC #3) had at least 5 undocumented incidents of aggression towards his peers and staff, at least 2 incidents of stealing or attempting to steal from staff, and at least 2 incidents of possessing contraband beginning in February or March of 2024 towards his peers and staff including the following :
-Attacking an eleven year old peer, (date unknown).
-Punching a former staff (unnamed) in the face breaking her glasses and and causing a injury when she attempted to break up a fight between FC#3 and a former peer (unnamed).
-Attacking client #1 (4-22-24).
-Attempting to fight former staff #1 (date unknow).
-Stealing a cigarette and lighter from the purse of staff #3 (date unknown).
-Attempting to steal from a staff's purse (unnamed staff/date unknown).
-Smoking in the bathroom (date unknown).
-Possessing contraband (a vape), (date unknown).
-Verbal aggression towards the QP when being questioned regarding having a vape in his possession (7-17-24).
-" told them (staff) to document the incidents."
-"We should have some incident repots. I tell the staff to document all incidents. I'm sure we have some. I can't locate them. We have a book that we keep them in but they are not in the book. They (staff) have not been documenting like we should."
-" I had a staff doing that (making sure the

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V 366	Continued From page 15 incident reports were completed) but when she left in February or March 2024, I guess we dropped the ball on that. That's on me, that was a ball drop." -"The staff that is involved in the incident is responsible for doing the incident report. I'm responsible for making sure the report is completed and placed in the record. That's my fault they (the incident reports) have not been done. I'm responsible for that." This deficiency constitutes a re-cited deficiency and must be corrected within 30 days This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies Of Qualified Professionals And Associate Professionals (Tag 109) for a standard level deficiency.	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:	V 367		

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(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 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

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V 367	Continued From page 17 .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 review and interviews, the facility failed to report II and III incidents to the Local Management Entity/Managed Care Organization (LME/MCO) responsible for the catchment area where services were provided within 72 hours of becoming aware of the incident. The findings are: Review on 8-26-24 of the Incident Response	V 367		

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V 367	Continued From page 18 Improvement System for May 1, 2024 to August 26, 2024 revealed: -Incident dated 8-6-24: "Provider 08/06/2024 The member (Former Client #3 (FC)) was on restriction due to going into two (2) staff member's (staff #3 and unnamed staff) pocketbooks and became angry when the staff (Former Staff #1 (FS)) advised that he (FC #3) could not have his MP3 player. The member turned over the office desk on the staff and they began to tussle. The staff member was able to get away from the staff and while the staff placed him in a therapeutic hold they (FC #3 and FS #1) tussled, and, both report to have injuries but neither of them have seen a docotor (doctor) at this time." -No documentation of allegation of FS #1 punching FC #3 in the face during the 8-6-24. No documentation of FS #1 cursing FC #3 (8-6-24). No documentation of FC #3's injuries including scratches on his neck and face, bruises and swelling on his face (8-6-24). -No documentation of staff #2's failure to intervene and protect FC #3 from abuse during the 8-6-24 incident. -No documentation of FC #3's 5 undocumented incidents of aggression towards his peers and staff, 2 incidents of stealing or attempting to steal from staff, or 2 incidents of possessing contraband beginning in February or March of 2024 towards his peers and staff including the following : -Attacking an eleven year old peer, (date unknown). -Punching a former staff (unnamed) in the face breaking her glasses and and causing a injury when she attempted to break up a fight between FC#3 and a former peer (unnamed). -Attacking client #1 (4-22-24). -Attempting to fight former staff #1 (date unknow).	V 367		

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-Stealing a cigarette and lighter from the purse of staff #3 (date unknown).
-Attempting to steal from a staff's purse (unnamed staff/date unknown).
-Smoking in the bathroom (date unknown).
-Possessing contraband (a vape), (date unknown).
-Verbal aggression towards the Qualified Professional (QP) when being questioned regarding having a vape in his possession (7-17-24).

Interview on 8-26-24 with the Associate Professional (AP) revealed:
-The AP and the QP are responsible for completing Level II and III incident reports into the IRIS system. "It's both our responsibilities. If I (AP) don't do it she (QP) will do it."
-"We (AP and QP) believe in grace. I believe we have to give these kids (clients) some grace. These are normal teenage behaviors. They are just acting like all kids their age. We don't want to write all that stuff up and have that on their record. Like I said we believe in grace. They (clients) are always doing something. If I wrote up every behavior they did I would be doing nothing but writing all day. We would have books and books and books on nothing but behaviors."

Interview on 8-26-24 with the QP revealed:
-"Yeah I talked to them (the clients and the staff) and asked them what happened.
-"They (client #1, FC #2 and FC #3) told me [FC #3] pushed the staff. Yeah they (clients) told me they (FS #1 and FC #3) were cursing each other out. I don't advocate staff cursing at the clients. But by that time I'm sure he (FS #1) was ramped up, the adrenaline was going and he was in that zone. He (FC #3) attacked [FS #1], pushed a table on him and was on him attacking him (FS

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V 367	Continued From page 20 #1)." -" No, I didn't write anything down." -"There was no abuse, it was a therapeutic hold. He (FC #3) was attacking a staff and he (FS #1) put him in a therapeutic hold. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies Of Qualified Professionals And Associate Professionals (Tag 109) for a standard level deficiency.	V 367		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is	V 500		

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prohibited from use within the facility; and
(2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client.
(d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify:
(1) the permitted restrictive interventions or allowed restrictions;
(2) the individual responsible for informing the client; and
(3) the due process procedures for an involuntary client who refuses the use of restrictive interventions.
(e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes:
(1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E);
(2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and
(3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention.

This Rule is not met as evidenced by:

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Based on record reviews and interview, the facility failed to ensure all incidents of alleged abuse was reported to the County Department of Social Services (DSS). The findings are:

Review on 8-26-24 of the facility's record revealed:
-No documentation to support County DSS notification for the 8-6-24 incident where former client (FC #3) was abused by former staff #1 (FS) and staff #2 failed to protect former client #3 during the incident of abuse.

Review on 8-26-24 of the Incident Response Improvement System (IRIS) revealed:
-Date of incident: 8-6-24.
-Submitted by the Qualified Professional (QP).
-No documentation of a report made to the local DSS regarding FC #1 abusing FC #3 or staff #2 failing to protect FC #3.

Interview on 8-26-24, and 9-16-24 with the Qualified Professional (QP) revealed:
-"There was no abuse. They (FC #1 and staff #2) put him in therapeutic hold because he attached a staff."
-"I did report it (the incident to DSS) cause I know that's what I'm suppose to do. No, I did not write anything down. No, I do not have any paper work from DSS but they came out and talked to the client's and everybody (unsure of date)."

This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies Of Qualified Professionals And Associate Professionals (Tag 109) for a standard level deficiency and must be corrected within 60 days.

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V 512	27D .0304 Client Rights - Harm, Abuse, Neglect	V 512		

10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION
(a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66.
(b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter.
(c) Goods or services shall not be sold to or purchased from a client except through established governing body policy.
(d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter.
(e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.

This Rule is not met as evidenced by:
Based on record reviews and interviews, 1 of 2 audited staff (Former Staff #1 (FS #1) abused 1 of 1 audited clients (Former Client #3 (FC #3), and 1 of 2 audited staff (staff #2) and neglected to protect 1 of 1 audited clients (FC #3). The findings are:

Review on 9-3-24 of former client #3's record revealed:

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-Date of admission: 8-17-23.
-Date of discharge: 8-7-24.
-Age: 15.
-Diagnoses: Attention Deficit Hyperactivity Disorder, Combined Type; Unspecified Trauma and Stressor Related Disorder.

Review on 8-27-24 of FS #1's record revealed:
-Date of hire: 5-24-24.
-Date of termination: 8-6-24.
-Job description for Direct Support Professional 5-1-24.
- Abuse/Neglect and Client Rights training 5-1-24
-Non-Violent Intervention (NCI) training 4-30-24.

Review on 8-27-24, 8-28-24 and 9-3-24 of staff #2's record revealed:
-Date of hire: 11-21-21.
-Job description for Direct Support Professional 6-21-21.
-NCI 4-30-24.
- Abuse/Neglect training 3-20-24.

Review on 8-26-24 of the Incident Response Improvement System from May 1, 2024 to August 26, 2024 revealed:
-Incident dated 8-6-24: "Provider 08/06/2024 The member (FC #3) was on restriction due to going into two (2) staff member's pocketbooks and became angry when the staff (FS #1) advised that he (FC #3) could not have his MP3 player. The member turned over the office desk on the staff and they began to tussle. The staff (FS #1) member was able to get away from the staff (FC #3) and while the staff placed him in a therapeutic hold they (FC #3 and FS #1) tussled, and, both report to have injuries but neither of them have seen a docotor (doctor) at this time."

Interview on 8-26-24 with client #1 revealed:

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-"[FS #1] asked [FC #3] for his [electronic device]. [FC #3] had been shouting in the house, he was not suppose to have it (electronic device). [FS #1] told him (FC #3) to go to his room and clean his room. [FC #3] got agitated and started calling [FS #1] names. [FC #3] called [FS #1] a 'p***y.' [FS#1] called [FC#3] a 'p***y' back. [FS #1] called [FC #3] a 'f****t' and said that's why you want one (a p***y). They (FC #3 and FS #1) were cursing each other out. [FC #3] got in [FS #1's] face. Then he (FC #3) punched him (FS #1) in his face with a closed fist. [FS #1] punched him back and they started fighting. No, it was a fight, they were fighting. [FS #1] definitely could have killed him (FC #3)."
-"[FS #1] backed off and told [FC #3] to go to his room. He (FS #1) went to the living room and sat down at the desk and [FC #3] rushed him. He (FC #3) pushed the table over on [FS #1] and he fell over. [FC #3] fell on top of him and they started fighting again. They were rolling around on the floor. [FC #3] was on top of [FS #1], then [FS #1] was on top of [FC #3]. He (FS #1) was trying to get him (FC #3) in a restraint. He (FS #1) had his knee on his neck. [FC #3] was yelling 'get off me, get off me.' Then he (FS #1) had [FC #3's] hands on [FC #3's] chest and [FS #1's] had his knees on his chest."
-"[FC #3] was crying. He was still cursing and telling [FS #1] to get off him. [FS #1] got [FC #3's] hands down by his side. [FS #1] was on top of him (FC #3) holding him (FS #1), holding his hands so [FC #3] couldn't move."
-'[FS #1] was telling [FC #3] to calm down."
-Not sure how long FS #1 was on top of FC #3.
-"[FS #1] got up and [FC #3] laid on the floor for a while. He was still crying. He was just laying there, kind of in a fetal position, whimpering a little bit. Umm, he (FC #3) laid there for about 10 minutes then he got up and went back to his

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room."
-"Yeah, he had some scratches on his face and neck. His neck and face was red. He had a bruise on his check, his left check. It was swollen a little bit. He said his foot hurt and he kind of walked around with a limp that day but I think he was milking that a little bit."
-"[Qualified Professional (QP) and Associate Professional (AP)] came in. Yeah, I talked to both of them. They asked us (clients) what happened. I told her [FC #3] hit [FS #1] and they got in a fight. Yeah, I told her (QP) exactly what I told you."

Interview on 9-3-24 with FC #2 revealed:
-FC #2 was in the bathroom and did not witness the initial altercation between FS #1 and FC #3.
-"I heard them (FC #3 and FS #1) arguing, they were cursing at each other. I didn't see the fight (initial fight). I'm not sure, I can't really remember specifics I just know they were going at each other."
-"I went back to my room cause I really didn't want to be involved in that."
-"When I came out of the shower, I saw [FS #1] on top of [FC #3]. [FC #3] was on the floor and [FS #1] was on top of him. He (FS #1) was punching him (FC #3) in his face. No, he (FC #3) couldn't move. [FS #1] had him pinned down and he (FS #1) was holding his hands."
-"About fifteen minutes then [FS #1] got up, [FC #3] stayed on the floor. He (FC #3) was crying on the floor. [FS #1] was cursing at him (FC #3). I can't really remember exactly, I know he called him a 'f****t.' That's all I remember. It was a lot going on."
-"Yeah he (FC #3) was hurt, he was limping and he had scratches on his neck. He said his jaw hurt."

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Attempted interviews with FC #3 and his guardian on 9-3-24, 9-6-24 were unsuccessful. No return call from FC #3 or guardian by survey exit.

Interview on 9-3-24 with FS #1 revealed:
-"I went to wake [FC #3] up to get ready for his day and noticed he had his [electronic device]. I asked him to give the [electronic device] to me. One of the staff (can't remember which one) had filled me in on [FC #3's] behaviors. He was not suppose to have the [electronic device]. He came at me like. "I aint giving you s**t.' 'I don't have to give y'all my s**t.' I redirected him to go clean his room. I had to redirect him a couple of times. He went in his room but I could hear him still mouthing in his room. I was at the table getting the meds (medications) ready. [Staff #2] was outside doing his morning check. [FC #3] runs out of his room and runs up to the table, grabs the table and flips the table over on top of me. I fall back, on my back. The table falls on top of me and [FC #3] is on top of the table. At that point he (FC #3) is on top of the table pushing the table down on me. I'm on my back trying to wrestle the table and him. I manage to get the out from under the table and then he (FC #3) is on top of me. We rolling around on the floor. I'm trying to get control of him to get him into a therapeutic hold. I manage to get on top and grab his hands. Oh yeah, he's still fighting, he's yelling and screaming. I'm telling him to calm down, calm down. I get his hands and pull them down to his sides. I'm straddling him. No, I don't have any weight on him, I'm on my knees so my weight is not on him. I just hold him there until he calms down. About two to five minutes. Then I release him and get up. I walk over to the door. I get the phone and call [QP] and let her know what's going on. She (QP) was already on her way (to the facility). As a matter of fact she

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(QP) and [AP] get there right after that. They both get there about the same time."
-Denied cursing at FC #3. "No, I never cursed him or used one curse word. I didn't even raise my voice other than to tell him to calm down."
-Denied placing his knee on FC #3's neck or chest. "No, I was no where near his neck or chest,"
-Denied punching or hitting FC #3 in his face or body. "No, I did not. I never put my hands on him other that to put him in the hold."
-Denied calling FC #3 a p***y or a f****t. "Absolutely not, he called me that but I never cursed him or called him out his name."
-Denied seeing any injuries on FC #3.

Interview on 9-3-24 with staff #2 revealed:
-"I was outside doing a parameter check around the house. I usually do that every morning before the guys (clients) get up to make sure that no one has dropped any contraband around the house. I was about half way around the house and I heard a commotion so I ran back around to the front. I opened the door and stood in the doorway to see what was going on and [FS #1] was on the floor straddling [FC#3]. [FC #3] was on the floor on his back. [FS #1] was standing over him, like one leg was at his waist level on one side of his body and the other leg was on the opposite side and he (FS #1) had his (FC #3's arms pinned). He (FS #1) was holding them so [FC #3] couldn't move. Yeah he (FC #3) was still trying to move, he was mad he was cursing (can't remember exact words) trying to get out of the hold. No, I didn't go in. He (FS#1) had it under control, I didn't think he needed my help. I stepped out in the yard and called [Qualified Professional (QP)] to let her know what was going on."
-"No, FC #3 did not ask me for help."
-"I'm not exactly sure how long he (FS #1) had

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him (FC #3) in the hold, I would say at least 10 minutes maybe...he (FC #3) finally calmed down. [FS #1] got up and stood back and he (FC #3) laid there (on the floor) for a minute or two then he got up and went to his room."
-"No, I didn't see [FS #1] put his knee around his (FC #3's) neck. At first, when I first opened the door he (FS #1) was trying to get him (FC #3) in the hold and he (FC #3) was struggling/he was fighting. [FS #1] got his arms and crossed them across his chest but he (FC #3) was fighting that. That's when he (FS #1) got his arms by his side and he was able to hold him there until he calmed down."
-"Yeah, I mean if there is two staff and we have to put someone in a restraint or hold we use two people. When I got there, he already had him in the hold. I never came in the house. I stood in the doorway the whole time. I was on the phone with [QP]."

Interview on 8-26-24 with the QP revealed:
-"I was already in route (to the facility) when [staff #2] called me. He (staff #2) just said that [FC #3] attacked [FS #1] and had to be put in a therapeutic hold. When I got there it was over (the hold). He (FC #3) was fine. He (FC #3) was laughing about it. He was walking around bragging about how he 'beat the staff's a**.'"
-No, he (FC #3) didn't have any injuries. I didn't see any busies, or scratches or swelling. He was a little red around his neck but that was from him tussling with the staff and being put in the therapeutic hold. I asked him if he needed medical attention and he told me no, a couple of times he refused medical care. He said 'no [QP], I'm good.' He said he wanted to go to school so he got ready and we took him to school."
-Yeah, I asked the clients and the staff (FS #1 and staff #2) about it and they all told me he (FC

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V 512	Continued From page 30 #3) was having a behavior and had to be put in a therapeutic hold. Yeah, they (client #1 FC #2,) said they (FC #3 and FS #1) were cursing at each other. I don't advocate staff cursing at any client but he (FS #1) was attacked. I'm sure by that time he was ramped up, in that zone. [FC #3] can definitely take you there (agitate you) when he is acting out." -"There was no abuse, it was a therapeutic hold, he (FC #3) was attacking a staff and he (FS #1) put him in a therapeutic hold. No, [Staff #2] was not suspended, he was not involved in the hold." Interview on 9-3-24 with the Day Program QP revealed: -Noticed FC #3 was upset as he was greeting clients as clients arrived at the day program. -"I went up to him and in passing asked him what was going on and he basically said he had gotten into a fight with one of the staff at the group home (facility). He said he and [FS #1] had gotten into a fight that morning" -"He (FC #3) reported that his jaw was hurting. His face was swollen and he had some scratches on his neck." -"No he did not ask to go to the doctor. No, he did not ask to go back home. The therapist came and got him and I think he disclosed more about the altercation to her. That's really all I know." Interview on 9-6-24 with the Day Program Therapist revealed: -"He (FC #3) came to my office and he was really upset. He said that he and one of the group home staff had gotten into a fight before he came to school. Apparently the staff was trying to take his [electronic device] and they got into what I understand was a verbal confrontation that escalated into a physical altercation. He (FC #3) expressed that he thought that his jaw may have	V 512		

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been fractured. He said he was having trouble closing his mouth and eating."
-"I asked him if he wanted to go back to the group home and he said no. I asked if he was afraid of the staff or if he was afraid of going back to the home and he said no that the staff was no longer there. I'm not sure if he (FS #1) got fired or quit but apparently the staff left that day so [FC #3] was fine with going back to the group home."
-No he did not ask to go to the doctor. His jaw was swollen and he had a bruise on his cheek. He had some scratches on his face and neck. We gave him an ice pack and he kept the ice pack on his face throughout the day. I kept a check on him throughout the day."
-"While he was in my office he did appear as if he was having some trouble eating. I had given him a snack. I can't remember what it was exactly and he looked as if he was in some pain as he was trying to eat his snack. I'm not sure if he had any trouble eating later in the day or not."
-"When the staff (QP) came to pick them up I mentioned to her that he had been complaining about his jaw hurting and that he said he thought it might be fractured and suggested they might want to take him to the ER (emergency room) or urgent care to have it checked out."

Review on 9-6-24 of photos sent to the DHSR surveyor by the Day Program Therapist of FC #3 revealed: five photos:
-Photo #1 was of the front of FC #3's neck and upper chest area and showed redness under FC #3's chin down to his adams apple, the upper part of his neck (at the top of his shirt collar) and at the top of his upper chest. He has what appears to be a scratch (approximately one to one and one half inches long) on the upper part of his neck just above the shirt collar.
-Photo #2 showed the back of FC #3's upper arm

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which appears to have 6 or more scratches in various lengths from approximately one half inch to 3 inches..
-Photo #3 showed a frontal view of FC #3's face, The lower jaw along the chin line was slightly swollen.
-Photo #4 showed a side view of FC #3's face. No injuries visible from photo.
-Photo #5 showed a side view of the back of FC #3's neck which showed redness from his hairline on the back of his neck to the bottom of FC #3's jawline.

Review on 9-18-24 of the facility's plan of protection dated and signed on 9-18-24 by the QP revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care?
We will follow our policy and procedure manual which indicates we will protect our children from self-harm as well as the safety of other's. We will conduct reviews of the "10A NCAC 27D .0101. POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS" and "10A NCAC 27D .0304. PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION" quarterly. We will retrain the staff on how to use the NCI skills to support members as they are proned to become hostile, aggressive and have times of outbursts and we will document all negative behavioral incidents.
Describe your plans to make sure the above happens.
We will schedule the NCI Plus training for the end of this month, September 2024. We will meet with the staff to review their knowledge of the practice quarterly. We will implement documentation and reporting of any outburst and non-compliance of treatment and goals that the staff observe from the members (clients). The staff will be required

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to keep record of incident reports for aforementioned behaviors. Bi-Weekly meetings will be scheduled with the staff to determine any problem areas they are experiencing with the members; documentation of said meetings will be kept for review."

Review on 9-19-24 of the facility's undated and unsigned amended plan of protection revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care?
The employee in question is no longer working for our agency as of August 7, 2024. The second staff member on duty at the time of the incident is on suspension until completion of NCI+ (National Crisis Interventions Plus). This staff will be closely monitored to ensure he is adhering to and practicing the skills learned.
Describe your plans to make sure the above happens.
All staff will be retrained on NCI+ (National Crisis Interventions Plus) by October 14, 2024.
Management will meet with staff weekly to review daily documentation to supervise the staff until training is completed. Before staff can place a member into a therapeutic hold they will need to contact the clinical staff which includes the Therapist, QMHP (Qualified Mental Health Professional), and/or the Associate professional.
Bi-weekly meetings will be held to discuss and review all incidents experienced in the home to ensure the staff can support the members with verbal interventions before situations escalate."

Review on 9-20-24 of the facility's amended plan of protection revealed: QP signed and dated the amended plan 9-19-24.

The facility served clients with diagnoses including ADHD Combined Type, and

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V 512	Continued From page 34 Unspecified Trauma and Stressor Related Disorder. On the morning of 8-6-24 FC #3 became upset when FS #1 attempted to take FC #3's electronic device. FC #3 punched FS #1 in the face and FS #1 punched FC #3 back which lead to a verbal and physical altercation between them. FC #3 and FS #1 got into a verbal and physical fight which included FS #1 calling FC #3 a p***y and a f****t and placing FS #1's knee on FC #3's neck and chest. Staff # 2 witnessed the altercation between FS #1 and FC #3 and failed to protect FC #3. As a result FC #3 sustained scratches, a bruise and a swollen jaw. No medical attention was obtained for FC #3. This deficiency constitutes a Type A1 rule violation for serious abuse and neglect and must be corrected within 23 days.	V 512		