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V 000	INITIAL COMMENTS A complaint survey was completed on 11-15-24. The complaints were substantiated (intake #NC00221774 and #NC00221737). Deficiencies were cited. This facility is licensed for the following service categories: 10A NCAC 3100 Nonhospital Medical Detoxification For Individuals Who Are Substance Abusers and 10A NCAC 5000 Facility Based Crisis Services For Individuals Of All Disability Groups. This facility is licensed for 16 and has a current census of 15. The 10A NCAC 3100 Nonhospital Medical Detoxification For Individuals Who Are Substance Abusers has a current census of 0 and the 10A NCAC 5000 Facility Based Crisis Services For Individuals Of All Disability Groups has a current census of 15. The survey sample consisted of audits of 2 former clients in the 10A NCAC 5000 Facility Based Crisis Services For Individuals Of All Disability Groups.	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking,	V 110		

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then qualified professionals and associate professionals shall demonstrate competence.
(e) 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.
(f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional.

This Rule is not met as evidenced by:
Based on record reviews and interviews, 2 of 2 paraprofessionals (former staff #1 (FC) and FC #2) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are:

Review on 10-25-24 of FS #1's record revealed:
-Date of hire: 11-27-23.
-Job Title: Behavioral Health Technician.
-Date of termination: 9-11-24 for neglect of FC #1 and FC #2.
-Oral/Verbal warning dated 7-23-24: "On 7-20 (2024), [FS #1] was seen using his cellphone on the unit with people we support (clients). It is important that [FS #1] does not us his cellphone when on the unit so he is able to provide the appropriate level of supervision to the people we

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serve (clients).
-Suspension notice dated 9-3-24: "[FS #1] was seen via the cameras (8-31-24) on is cellphone when an incident occurred between two youths. [FC #1] was then suspended pending investigation for allegations of neglect."
-Termination notice dated 9-11-24: "Conclusion of investigation was that the allegation of Neglect was substantiated."

Review on 10-25-24 of FS #2's record revealed:
-Date of hire: 6-24-24.
-Job Title: Behavioral Health Technician.
-Date of termination: 9-10-24 for neglect of FC #1 and FC #2.
-Suspension notice dated 9-4-24: "On 9-3-24 it was discovered that 2 PWS (persons we serve) were in the bathroom together on 8-28-24 (incorrect date on report), {FS #2] appeared to be asleep during the incident."
-Termination notice dated 9-11-24: [FS#2] was seen sleep (8-31-24) on camera not providing adequate supervion to the people we support which resulted in an incident. The findings from the pending investigation is the allegation for neglect has been substantiated.

Review on 11-4-24 of the facility's video footage on 8-31-24 revealed:
Video #1 titled "Adolescent Exit Corridor," time stamped 21-59-21 (9:59 pm), 3 minutes and 24 seconds. There was no audio with the video: At 8 seconds into the video, FC #1 walked down the corridor away from the nurses station (approximately 40 to 50 feet) and stopped in font of a closed door on the opposite side of bathrooms #1 and bathroom #2 and stands just off camera. 33 seconds into the video FC #2 is seen walking from the day room area. FC #2 walked past the nurses station down the corridor

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and walked towards the area where FC #1 was standing. At minute 1:09 FC #1 is seen with her right hand around FC #2's upper back. FC #2's left hand is around FC #1's waist. At minute 1:12 FC #2 turns FC #1 around to where she is facing the wall. FC #2 grabbed FC #1's left arm, places his right hand on FC #1's upper right shoulder area and bends her over at her waist. FC #1 is bent over at her waist and FC #2 is standing behind FC #1. FC #1 pulled away from FC #2 (she is smiling) and he lets her go. At minute 1:18 FC #2 walked back down the corridor (towards the nurses station). FC #1 followed FC #2 down the hallway but stopped approximately halfway down the hall and walked back to the previous area. FC #2 stopped at the nurses station. At 1:37 FC #2 is seen throwing an object into the day room, then he walked back down the corridor where FC #1 was still standing. FC #1 FC #2 both walked back down the corridor towards the nurses station. FC #1 stops approximately 5 to 10 feet from the nurses station then walks out of the cameras view towards bathroom #2. At minute 3:03 FC #2 can be seen walking from the day room towards bathroom #2 outside the camera's view. The video ends at 3:23.
-Video #2 titled "Nurses station 1," time stamped 22-6-34 (10:06 pm), 6 minutes and 23 seconds. There was no audio with the video: This view is from the inside of the nurses station and shows the front open end of the nurses station in which clients and staff have access to the nurses as well as views of bathrooms #1 and #2. At 12 seconds into the video FC #2 exited bathroom #2 and FS #1 entered the nurses area from the day room. FS #1 and FC #2 pass each other with thier mouths moving as they pass. FS #1 goes to bathroom #2, opened the door and looked in. He closed the door and stood by bathroom #2's door. At 49 seconds into the video, FC #2 walked back

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towards the nurses station and towards FS #1 at 57 seconds the nurse comes into the frame and the nurse, FS #1 and FC #2 are standing at the nurses station with their mouths moving. At minute 1:31 into the video FC #1 exited bathroom #2 and walked to the nurses station. FC #1, FS #1, FC #2 and the nurse are facing each other and their mouths are moving. At minute 1:57 FC #2 walked back towards the day room. FS #1, FC #1 and the nurse continue to stand at the nurses station with their mouths moving. At minute 2:35 FC #2 walked past the open window on the left side of the nurses station. At minute 3:11 FS #1 walked down the corridor away from the nurses station out of the camera view. FC #1 and the nurse remained at the nurses station and their mouths were moving. At minute 4:15 FC #1 walked back toward bathroom #2 out of camera view. At minute 4:34 FC #1 entered bathroom #2 and threw a object in the trashcan then exits the bathroom. FC #1 walked back to the nurses station and waited on the nurse to hand her an item then walked down the corridor away from the nurses station out of camera view. At minute 5:20 FS #1 walked past the nurses station towards the day room. FC #1 walked back to the nurses station and waits (the nurse does not appear in the frame). At minute 5:37 FC #1 walked back down the corridor away from the nurses station. Video ends at 6:23
-Video #3 titled "Adolescent day room," time stamped 22-1-22 (10:12pm), 9 minutes and 11 seconds long. There was no audio with the video : A large room to the left of the nurses station with 3 small tables. Two bathrooms could be seen directly in front of the nurses station. FS #1 and FS #2 were sitting at a table to the far left of the room.
FC #2 could be seen walking between the nurses station, going towards bathroom #1 and back into

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the day room. FC #1 is seen entering bathroom #2 at 54 seconds into the video. FC #2 is seen walking towards bathroom #1. He did not enter bathroom #1 but he closed the door to bathroom #1. At minute 1:44 FC #2 walked to bathroom #2 where FC #1 was and entered, shutting the door behind him. FS #1 is seen sitting slightly slumped (laid back in the chair) with his head down looking at a cellphone. His fingers were moving over the cellphone, while FS # 2 was sitting in his chair with his head bowed, not moving. At minute 4:20 FS #1 looks up from his cellphone, his mouth is moving, then he returns to looking at his cellphone At 5 minutes and 15 seconds into the video, FS #1 sits up in his chair and gestures (uses his left hand/arm to point) while his mouth is moving. At minute 5:23 FS #1 gets up out of his chair and walks toward bathroom #2. At 5:25 FC #2 walked out of bathroom #2 and walked towards the nurses station. FS #1 and FC #2 passed each other. As FS #1 and FC #2 passed each other their mouths were moving.. At minute 6:47 FC #1 exited bathroom #2 and approached the nurses station. FS #1, FC #1, FC #2 were at and around the nurses station with their mouths moving. At minute 7:16 FC #2 walked away from FS #1 and FC #1 and walked into the day room. FC #2 began to assist with moving furniture around the day room. FS #1 and FC #1 remained at the nurses station with their mouths moving until moving out of the cameras view. At 8:02 FS #2 got up from his chair, and moved around the table he had been sitting at and shuffled papers that were lying on the table. FS #2 went to the far left wall where some chairs had been placed and sat down in one of the chairs. The video ended at 9:11.

Review on 10-25-24 of facility's incident reports revealed an internal investigation dated 9-10-24

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and signed by the Director of Operations/DO that documented the following incident: "On 9-3-24 [staff #3] informed [Program Manager/PM] that [FC #1] and [FC #2] were together in the bathroom on August 31, 2024. At approximately 1:29PM, [PM] notified [DO] who was offsite of the incident and indicated he would review the camera footage. By 1:35 PM, [PM] and [Nurse Manager/NM] had reviewed the footage and confirmed the incident..."

Review on 10-25-24 of the North Carolina Incident Response Improvement System (IRIS) revealed a report submitted on 9-4-24 documenting the following: "It was reported that a female patient (FC #1) went into the bathroom and a male patient (FC #2) followed her. Both patients were viewed on the camera as being in the bathroom for a total of 4 minutes. One staff (FS #2) appeared to be asleep, and another staff member (FS #1) was on his cell phone."
-9-4-24 Healthcare Personnel Registry report documenting the following: "It was reported that a female patient (FC#1) went into the bathroom and a male patient (FC #2) (17 years old) followed her. Both patients (clients) were viewed on the camera as being in the bathroom for a total of 4 minutes. One staff appeared to be asleep (FS #2), and another staff member (FS #1) was on his cell phone."

Attempted interview on 11-6-24 with FS #1 was unsuccessful. Phone call and message left for FS #1 on 11-6-24 was not returned by survey exit date.

Interview on 11-6-24 with FS #2 revealed:
-"I don't know what happened (8-31-24). I didn't see them (FC #1 and FC #2) go in the bathroom."
-"When we (staff) are in the day room, the way

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the day room is sat up we can see where all the clients are at all times.
-No, I wasn't sleeping. I had knee surgery, (unknown date) I had to have fluid drained off my knee. When they (supervisor) called me to come in I told them I couldn't walk, that I would have to sit down."
-"We (staff) are suppose to watch the clients to make sure they are safe. We do activities with them, play games, watch tv, talk to them help them deal with what's going on with them."
-"At the end of the shift (8-31-24), [FS #1] was doing the report and he told me that two clients were in the bathroom together but that it was an accident (FC#2 accidentally walked in on FC #1 in the bathroom). He said it was no problem, it was handled."
-"No I didn't report it because he (staff #1) said it was no problem. I didn't know anything about them (FC #1 and FC #2) being in the bathroom for a long time. [FS #1] said it was an accident."
-"Yes, policies and procedures were covered when I was hired."

Interview on 11-7-24 with staff #3 revealed:
-Worked the 7am to 7pm shift.
-"I came in that morning (9-1-24). We (staff) usually do like a hand off (shift report) where we update the staff coming on shift on what happened during the shift. [FS #1] was doing the report. He (FS#1) said the shift went good, there was no issues, everything was good. As he was wrapping up (the shift report), he mentioned that [FC #2] had accidentally walked in the bathroom on [FC #1]. He (FS#1) said it almost like an afterthought. He said it was no big deal that it was an accident and that it (FC#2 accidentally walked in the bathroom on FC #1) was handled. I actually didn't think anything about it because he (FS #1) wasn't reporting it like it was an incident.

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V 110	Continued From page 8 He just said it (FC #2 walking in the bathroom on FC #1) like it was just something that happened on the shift. I actually was thinking to myself, 'well why are you even telling me this if it's not an incident?'" -"Later on, as the shift went on , I started hearing the other PWSs (person we support) (clients) talking and laughing about it (FC #1 and FC #2 being in the bathroom together). At first they were just laughing, giggling about it, you know like how kids act. I actually tried to redirect them and told them to stop talking about it. The next day (9-2-24), they (clients) were still talking about it (FC #1 and FC #2 being in the bathroom together) but this time I was hearing that it wasn't an accident. Again I got on to them (clients). Then I started hearing the sex word. They were teasing [FC #1]. I told them they really couldn't be gossiping and talking about someone especially talking about something like someone having sex in a bathroom. They were saying 'no it's true, it's true.' [FC #2] told them that [FC #1] gave him a b**w J**b (oral sex) in the bathroom. [FC #2] was gone (discharged) by that time. I asked [FC#1] she said it wasn't true (allegation that FC #1 and FC #2 had sex in the bathroom). She was upset she denied everything. She said the other PWSs were lying on her just trying to get her in trouble. By that time I decided that I needed to report this to someone." -Reported incident to the PM on 9-3-24. Interview on 11-4-24 with the Nurse revealed: -She was the nurse on duty on 8-31-24. -"[FS #1] came by the nurses station. Not exactly sure of the time but it was sometime during the 10 pm hour. As he (FS #1) walked by he told me that [FC #2] had accidentally walked in the bathroom on [FC #1]." -"I didn't see either of them (FC #1 or FC #2) go	V 110		

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into the bathroom but I was sitting in the back of the room doing documentation."
-"No, he (FS #1)didn't say it like it was a problem he explained that he was walking by the bathroom and [FC #2] came out and he asked him what he was doing and [FC #2] said he went in to use the bathroom but [FC #1] was already in there. He said he opened the door and [FC #1] was in the bathroom."
-"They both (FC#1 and FC #2) denied anything happened. They both said it was an accident. They both said that [FC #1] was in the bathroom and [FC #2] didn't know she was in there and that as soon as he realized she was there he left."
-Yes, I asked her (FC #1) about it. I asked her a couple of times and she denied anything happened...
-"No," she did not report the incident to anyone because FS #1 told her FC #2 accidentally walked in the bathroom while FC #1 was in the bathroom.

Interview on 10-25-24 with the PM revealed:
-He was notified on 9-3-24 by staff #3 of an allegation that FC #1 and FC #2 were unsupervised in the bathroom together on 8-31-24.
-"I immediately called my supervisor, the DO, who was off that day (9-3-24), I called her and informed her of the allegations. Then I contacted the Director of Nursing and she and I pulled the video footage and reviewed the video footage and confirmed the two clients (FC #1 and FC #2) were alone in the bathroom together. The video showed [FS #1] was playing on his phone and [FS #2 was asleep]. We immediately suspended (FS#1). [FS #1] was working that day so we suspended him when he came in for his shift. [FS #2] was off (not scheduled to work) so since it was so late in the day when all this came to light,

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V 110	Continued From page 10 we called him the next day (9-4-24) and suspended him." Interview and observation on 10-25-24 at approximately 2pm with the PM and the DO: PM explained per facility policy, staff are not allowed to use their cellphones while they are working with clients, to which the DO who was present nodded her head in agreement. -"Cellphones are not allowed on the unit. Staff are not suppose to be on their cell phones when they are working with clients." Interview on 10-25-24 with the DO revealed: -"I was notified on 9-3-24 of the incident. I informed the PM to suspend [FS #1] and [FS#2] immediately and I begin the internal investigation on 9-4-24. The internal investigation was completed on 9-10-24. The allegation was substantiated and both staff were terminated on 9-11-24 for neglect of FC #1 and FC #2. Interview on 11-4-24 with the PM revealed: -"There's always two or more staff working on the unit depending on the number of clients we have at the time. Staff are suppose to position themselves in the room so that no matter where a client is staff will have eyes on them..."	V 110		
V 318	13O .0102 HCPR - 24 Hour Reporting 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of	V 318		

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V 318	Continued From page 11 the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g). This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the Healthcare Personnel Registry (HCPR) of allegations of neglect within 24 hours of learning about the allegation affecting 2 of 2 audited staff (FS #1 and FS #2). the findings are: Refer to V 110 regarding FS #1 and FS #2 record review, Video 1-3 regarding the incident on 8-31-24 FS #1 discovered the incident on 8-31-24, the facility's internal investigation, the North Carolina Incident Response Improvement System report and staff and client interviews.	V 318		