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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECU YOUTH CRISIS CENTER, A MONARCH PROGR	1810 BACK CREEK DRIVE CHARLOTTE, NC 28213

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 3/11/25. The complaint was unsubstantiated (Intake #NC00225512). Deficiencies were cited. This facility is licensed for the following service categories: 10A NCAC 27G .3100 NonHospital Medical Detoxification For Individuals Who Are Substance Abusers and 10A NCAC 27G .5000 Facility Based Crisis Service for Individuals of all Disability Groups. This facility has a current census of 15. The .3100 NonHospital Medical Detoxification For Individuals Who Are Substance Abusers has a current census of 0 and the .5000 Facility Based Crisis Service for Individuals of all Disability Groups has a current census of 15. The survey sample consisted of audits of 2 current clients and 2 former clients.	V 000		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual	V 512		

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V 512	Continued From page 1 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 6 audited paraprofessional staff (Staff #2) subjected 1 of 2 Former Clients (FC #4) to substantial risk for serious harm and abuse. The findings are: Review on 3/10/25 of FC #4's record revealed: - Admission date 11/15/24; - Age 12; - Diagnoses-Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder, Child Physical Abuse Suspected, Cannabis Use Disorder, Mild; - Discharge date 12/23/24. Review on of Staff #2's personnel record revealed: - Hire date 10/21/24; - Job title- Behavioral Technician, Child Crisis; - Safety Care, training in seclusion physical restraint and isolation time 10/24/24; - Ukeru, training in alternative to restrictive interventions 12/6/24. --No documentation of retraining on client abuse after the 11/28/24 incident with FC #4. Review on 2/13/25 of Incident Response	V 512		

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V 512	Continued From page 2 Improvement System (IRIS) revealed: - Level II incident submitted for FC #4 on 12/1/24; - Cause of incident and allegations are described as follows: "[FC #4] reported to the Director that he had been antagonizing his peer for most of the day. That evening, the peer whom [FC#4] had been antagonizing walked by him and requested that he not walk behind him, as it was a trigger. An exchange of words followed, and despite staff efforts to intervene, [FC#4] bypassed staff and attacked his peer. Staff promptly separated the two patients, and [FC #4's] peer was removed from the unit. However, [FC #4] continued to escalate, necessitating a two-minute restrictive intervention. The police were called, but by the time they arrived at 6:19 PM, [FC #4] had already calmed down. The police spoke briefly with the patient and left the unit at 6:26 PM; - Incident Prevention: Staff will continue to receive ongoing education on de-escalation techniques to prevent incidents, including participation in quarterly refreshers for Ukeru (Alternative to Restrictive Interventions) and Safety Care (Alternative to Restrictive Intervention and Restrictive Interventions). They will employ these techniques and, if unsuccessful, will seek assistance from additional clinical staff such as OTAs (Occupational Therapy Assistant), Therapists, COTAs (Certified Occupational Therapy Assistant), and Nurses as needed. Additionally, staff will promptly notify nurses of any reported or identified health concerns, including any verbalizations of self-harm." Review on 2/13/25 of the facility's Investigation Summary findings report dated 12/2/24 written by the Director of Operations revealed: - Introduction- "On Thursday, November 28th, 2024, the Program Manager was informed of a	V 512		

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V 512	Continued From page 3 physical altercation between two youths and subsequently notified the director around 6:00 PM. On Friday, November 29th, the Program Manager and Director spoke with one of the team members involved. Upon reviewing the camera footage on Friday, it was inconclusive whether the RI (Restrictive Intervention) was conducted correctly. On Saturday, November 30th, at approximately 10:52 AM, The VP (Vice President) of Operations informed the Director and Program Manager that both team members (Staff #1, Staff #2) involved would be suspended to conduct an investigation on the use of the Ukeru mat and hold. The suspensions were enacted at around 11:15 AM on the same day." - Conclusion- "Upon reviewing the camera footage, the Director was unable to determine if [Staff #1] executed the hold correctly due to a blind spot in the unit. Based on [Staff #1]'s statement, when she held the patient's (FC #4) arm to prevent self-harm, it was not an appropriate Safety Care hold. This blind spot prevented a clear view of the action, making it difficult to assess the situation accurately." - Internal Review Determination- "The Restrictive Intervention review team met on 12/3/2024 to assess the actions of staff (Staff #1, Staff #2) during the restrictive intervention. It was determined that staff did not use excessive force during the incident but did not utilize the proper Safety Care techniques or use the Ukeru mat in accordance to the training. Individual was not injured in this incident due to improper techniques." - Recommendations- "Based on the investigation findings and the review of camera footage, the Program Manager will assign additional Relias classes, including de-escalation, conflict resolution, and other relevant training to address this situation. This will help both team members	V 512		

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V 512	Continued From page 4 succeed in their roles as BTs (behavioral technicians). - Both team members (Staff #1, Staff #2) will be required to attend an Ukeru class this month. Additionally, they will each receive a coaching session. - Staff will be shown the camera footage and provided with feedback on both successful and unsuccessful actions. They will also have the opportunity to voice any concerns they may have. - To prevent future incidents, one-on-one coaching sessions with leadership are recommended to review the camera footage and discuss alternative approaches and best practices. These sessions will be conducted to allow the staff member to reflect on the incident, receive constructive feedback, and develop a plan for improvement." Review on 2/25/25 of the facility's video surveillance on 11/28/24 revealed: - Video titled "DC15-SECU (Licensee) Child Exit Corridor" time stamped November 28, 2024, 06:05:28 PM, 4 minutes 31 seconds: - - At 6:05:51- Staff #2 stated "We are going have to get him (FC #4) outside, let's go outside, let's go outside;" - At 6:05:57- FC #4 stated "Get off me dude;" - At 6:05:58- 6:06:24 Staff #1, Staff #2 and FC #4 were in the area with no video surveillance-you can only hear them talking-unknown staff member stated "you not going in there, you not getting in the room, you might as well go outside and cool off because you not getting in there, the door is not going to open;" Staff called FC #4's name, then said "[FC #4] let's go outside;" - From 6:06:25-6:06:29-(back in front of the camera) FC #4 was trying to get past Staff #1 with Ukeru mat, Staff #1 was trying to block (moving forward with the ukeru mat) FC #4 from	V 512		

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getting past her, FC #4 grabbed the mat and pushed it over towards the right side of the wall while Staff #1 was still holding on to the mat and then goes past Staff #1 into the area where was no video surveillance;
- From 6:06:-6:07:03- Staff #1 and FC #4 were out of view and staff members were seen on camera talking to FC #4 trying to get him to calm down and go outside;
- At 6:07:08- 6:08:14-Staff #1 and FC #4 were back in the area with no video surveillance- staff members were heard talking to FC #4 telling him there was a visit out there, he was not able to get through the doors and telling him to go outside;
- At 6:08:20- Staff #1 pushed forward with the Ukeru mat towards FC #4; Staff #2 grabbed FC #4 from behind by both upper arms but FC #4 immediately jerked away from Staff #2 and stated "Get off me son;" FC #4 hit the mat (that Staff #1 was holding), FC #4 went to the area with no video surveillance;
- At 6:08:27-6:08:56- Staff #1 and FC #4 were in area with no video surveillance, Staff could be heard talking to FC #4, telling him he could not swing on them (staff). Staff stated "I know you are mad but you can't be throwing punches at us." Staff stated " I'm not going to pull on you, I just want you to go outside;"
- At 6:08:59-6:09:04- As FC #4 tried to go back towards the area with no video surveillance, Staff #2 grabbed FC #4's left arm a second time and pulled him around the corner of the nurse's station before FC #4 was able to pull away. FC #4 went back to area with no video surveillance;
- At 6:09:14- FC #4 was directly in front of Staff #2, when she grabbed FC #4 for the third time by the left arm and began to pull him down the hallway;
- At 6:09:16- FC #4 slipped on the floor, but managed to break his fall with his right hand. He

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regained his footing as Staff #2 continued to pull him by his left arm. FC #2 displayed resistance as Staff #2 continued to pull his left arm while proceeding down the hallway, eventually moving out of camera footage.

Attempted Interview on 3/10/25 with FC #4 and his guardian revealed no return call from FC #4 and guardian by survey exit.

Interview on 2/14/25 with Staff #1 revealed:
- FC #4 was trying to fight one of his peers on 11/28/24;
- Separated clients by having them on different units;
- FC #4 continued to yell and tried to get to the other unit;
- There was an investigation to determine "whether I did the intervention correctly;"
- Suspended for three days;
- Retrained in Ukeru.

Interview on 2/14/25 with Staff #2 revealed:
- "I was seen forcibly moving him (FC #4) outside and here you are not supposed to put your hands on them (clients) even though it was for a purpose."
- Suspended for three days;
- Retrained in Ukeru.

Interview on 3/8/25 and 3/12/25 with the Training Specialist revealed:
- "They (Staff) are directly taught not to move forward, they should stay in a backward motion" when using the Ukeru mats;
- "There is a reflection jerk when you meet the blow (client hitting the Ukeru mat);"
- Did not typically watch the video surveillance to see if staff used Ukeru or Safety Care techniques correctly.

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V 512	Continued From page 7 Interview on 3/11/25 with the Program Manager revealed: - Debriefed with Staff #1 and Staff #2 on 11/28/24 after incident with FC #4; - Discussed with Staff #1 and Staff #2 what was done correctly and what they needed improvement on; - Staff #2 did not pull FC #4 in a "forceful nature but more of guiding him." Interview on 3/11/25 with the Director of Operations revealed: -"Trauma covered identifying behaviors that a client may have experienced due to abuse and neglect which would then show the staff how to interact with a client with trauma." Review on 3/11/25 of the Plan of Protection dated and written on 3/11/25 by the Director of Operations revealed: - "What immediate action will the facility take to ensure the safety of the consumers in your care? -Managers debriefed with staff immediately following the incident. -Staff took additional Ukeru training on 12/6/2024 which includes de-escalation techniques. -Further training was also completed by both staff, on 12/20/24 &12/27/24. -Manager met with respective staff and provided 1:1 coaching and support after investigation outcome. -[Staff #2] will retake Safety Care on 3/17/2025. - Describe your plans to make sure the above happens. -Managers (Program Manager, Director of Operations, Crisis, & Nurse Manager, Crisis) will continue to complete the Weekly Monitoring Tool	V 512		

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V 512	Continued From page 8 onsite, which includes site walk-throughs, feedback in real time, support on the floor for scenarios, video monitoring, checking in with patients (clients). -Monthly Staff meeting to review de-escalation techniques and possible scenarios. -Director of Operations, Crisis or designee to review video footage of all incidents." The facility served clients with diagnoses of Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Post Traumatic Stress Disorder, Generalized Anxiety Disorder and Disruptive Mood Dysregulation Disorder ranging in age 12-17 years. On 11/28/25, FC #4 was engaged in a behavioral incident when Staff #2 grabbed FC #4 by the arms and attempted to move him outside when he jerked away. Staff #2 grabbed FC #4's left arm a second time and pulled him around the corner of the nursing station before he was able to pull away. Staff #2 grabbed FC #4 for the third time by his left arm and pulled him around the nursing station, where he lost his footing. He broke his fall with his right hand and regained his footing as Staff #2 continued to pull him by the left arm down the hallway without letting go, eventually moving out of view. This deficiency constitutes a Type A2 rule violation for substantial risk of serious harm and abuse and must be corrected within 23 days.	V 512		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives	V 536		

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to restrictive interventions.
(b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented.
(c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered.
(d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(e) Formal refresher training must be completed by each service provider periodically (minimum annually).
(f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.
(g) Staff shall demonstrate competence in the following core areas:
(1) knowledge and understanding of the people being served;
(2) recognizing and interpreting human behavior;
(3) recognizing the effect of internal and external stressors that may affect people with disabilities;
(4) strategies for building positive relationships with persons with disabilities;
(5) recognizing cultural, environmental and

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organizational factors that may affect people with disabilities;
(6) recognizing the importance of and assisting in the person's involvement in making decisions about their life;
(7) skills in assessing individual risk for escalating behavior;
(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and
(9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).
(h) Service providers shall maintain documentation of initial and refresher training for at least three years.
(1) Documentation shall include:
(A) who participated in the training and the outcomes (pass/fail);
(B) when and where they attended; and
(C) instructor's name;
(2) The Division of MH/DD/SAS may review/request this documentation at any time.
(i) Instructor Qualifications and Training Requirements:
(1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.
(2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.
(3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.

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V 536	Continued From page 11 (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate	V 536		

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V 536	Continued From page 12 competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 6 audited paraprofessionals (Staff #4) failed to implement practices that emphasized the use of alternatives to restrictive interventions. The findings are: Review on 2/21/25 of Former Client (FC) #3's record revealed: - Admission date 12/16/24; - Age 14; - Diagnoses- Generalized Anxiety Disorder, Unspecified Attention Deficit Hyperactivity Disorder, Mood Disorder; - Discharge 12/17/24. Review on 3/11/25 of Staff #4's personnel record revealed: - Hire date 4/29/24; - Job Title Behavioral Technician, Child Crisis; - Ukeru, training in alternative to restrictive interventions 12/6/24. Review on 2/13/25 of Incident Response Improvement System (IRIS) revealed: - Level II incident submitted for FC #3 on 12/18/24;	V 536		

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SECU YOUTH CRISIS CENTER, A MONARCH PROGR	1810 BACK CREEK DRIVE CHARLOTTE, NC 28213

(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 536	Continued From page 13 - Cause of incident and allegations are described as follows: "The patient (FC #3) became agitated when informed that she could not close her door during relaxation time. She then became combative and began striking a team member (Staff #3). The team member retrieved the Ukeru mat to allow the patient to hit it. The patient returned to her room and began banging on the window and walls, requesting to leave. She then stormed out of the room, prompting two team members to retrieve the Ukeru mats again to allow her to hit them. The police arrived on the unit at approximately 7:27 PM. The patient continued to swing at the staff and, at around 7:32 PM, attempted to hit one of the police officers. The officer then initiated a restraint intervention (RI), which lasted from 7:32 PM to 7:37 PM. No injuries were sustained by the staff, patient, or officer; - Incident Prevention- Staff will persist in utilizing de-escalation techniques and, if these are unsuccessful, will seek assistance from additional clinical staff as needed. They will also continue to notify nurses of any reported or identified health concerns, as well as any verbalizations of self-harm. Staff will maintain the use of Ukeru Mats to safely manage Dysregulation youth." Review on 2/25/27 of the facility's video surveillance on 12/17/24 revealed: - Video titled "DC15-SECU Child Exit Corridor" time stamped December 17, 2024, 07:13:59 PM, 15 minutes 42 seconds: - At 7:06:18 FC #3 closed bedroom door; - At 7:06:30- Staff #4 opened FC #3's bedroom door and stated "you can't have your door closed." FC #3 stated "I don't f******g care, leave me the f**k alone;" - At 7:06:49- Staff #6 came and stood beside FC #3's bedroom door;	V 536		

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V 536	Continued From page 14 - At 7:07:02- FC #3 attempted to close the bedroom door again, Staff #6 informed FC #3 that she could not close the door, she was a 1:1, FC #3 stated she didn't care; - At 7:07:07- FC #3 was behind the bedroom door; Staff #6 was standing in front of the bedroom door; - At 7:07:16- Staff #6 had both arms and left foot against the bedroom door; FC #3 was behind the door trying to close the door; FC #3 was yelling "let me close my f*****g door," Staff #6 told her "no ma'am; - At 7:07:22- 7:07:49 Staff #4 came back to FC #3's bedroom and stood at the bedroom door as Staff #6 continued to hold the door open with her two hands and foot. FC #3 was behind the door pushing the door and telling Staff #6 to move; - At 7:07:50- Staff #4 put his left hand on the door; - At 7:07:54- 7:08:08 - FC #3 is observed pushing the bedroom door from the inside while Staff #4 is observed with both hands on the bedroom door, left foot braced against the door while applying ongoing steady pressure on the door while FC #3 pushes from the rear. Staff #6 still had hands on the door as well. - At 7:08:08- FC #3 came from behind the door and started to attack by hitting Staff #4, Staff #6 tried to get in between FC #3 and Staff #4; - At 7:08:16-7:08:40 Staff #4 picked up an Ukeru mat as FC #3 came out of the bedroom towards him. FC #3 was attempting to hit Staff #4. Staff #4 took the Ukeru mat and moved towards FC #3 three different times when she attempted to hit staff #4. When FC #3 realized she was unable to hit Staff #4, she reentered her bedroom and tried to close the door; - At 7:08:41- FC #3 tried to hit Staff #4 once again and Staff #4 held up the mat to block the hit, Staff #5 continuously asked FC #3 what was she	V 536		

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doing, FC #3 continuously stated for staff to leave her alone;
- At 7:08:42-7:11:59- Staff #4 stood in the door and put his body on the door with his arm at times extended holding on to the frame of the door, while FC #3 continued to stand behind the door and tried to push the door closed. Staff #3 attempted to talk with FC # 3 but she told staff to leave her alone. Staff #3 just stood there and watched until it was decided for him and Staff #4 to switch out;
- At 7:12-7:15:42- Staff #3 stood in the bedroom doorway at a stance with left foot inside the bedroom and right foot at the right side entrance of the door, holding the Ukeru mat in his hands, until video ended.

Interview on 2/28/25 with Staff #3 revealed:
- FC #3 was on a 1:1(1 staff to 1 client ratio) and unable to close her bedroom door;
- FC #3 went into a crisis, kicking, throwing punches and "trying to slam people feet in the door;"
- Used the Ukeru mat while FC #3 was in crisis;
- Staff tried to keep the door open so FC #3 would not harm herself;
- The local police were contacted due to FC #3 continuous behavior and was transported to the local hospital by Emergency Medical Services (EMS)
- "We were told we did a good job by supervisor;"
- Did not receive any training after the incident.

Interview on 2/28/25 with Staff #4 revealed:
- FC #3 was sent to her room for reflection time;
- FC #3 became upset because her bedroom door had to stay open and staff monitor;
- FC #3 started cursing, and said "I would just close my door;"
- Informed FC #3 she was on a 1:1, therefore the

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door could not be closed;
- FC #3 became escalated and tried to closed the door;
- Staff had to stand in the doorway to prevent the door from being shut;
- Grabbed the Ukeru mat when FC #3 started to attack to prevent her from hitting;
- "I do know if I was antagonizing her or not;"
- "I removed myself from the situation" when the incident settled down;
- Denied moving towards client with the Ukeru mat;
- Supervisor called and stated "It looked like I was pushing the pad (Ukeru mat) out towards her as opposed to keeping the pad back towards me and backing up and giving space;"
- Did not receive any retraining.

Interview on 3/11/25 with Staff #6 revealed:
-Did not know why FC #3 was in her room;
- Engaged in the incident in hopes of de-escalating the situation on 12/17/24;
- Placed foot in the doorway so FC #3 could not close the door;
- FC #3 pushed the door against staff #6's foot and tried to close the door;
- Staff #4 came and assisted with holding the door open;
- FC #3 was behind the door trying to push us out and we (Staff #4 and Staff #6) were in front of the door trying to keep it opened.
- Staff #4 was on the door, pressing back and forth, "teasing with her a little bit; that is when she got mad and moved from around the door and started swinging;"
- FC #3 targeted Staff #4;
- Staff #4 picked up the Ukeru mat;
- Picked up Ukeru mat, "I didn't really need to because she wasn't a threat to me ...I did anyway

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for safety reasons;"
- Someone else came to assist and Staff #6 left the situation at that point;
- Did not receive any debriefing or retraining.

Interview on 3/8/25 and 3/12/25 with the Training Specialist revealed:
- "They (Staff) are directly taught not to move forward, they should stay in a backward motion" when using the Ukeru mats;
- "There is a reflection jerk when you meet the blow (client hitting the Ukeru mat);"
- Did not typically watch the video surveillance to see if staff used Ukeru or Safety Care techniques correctly.

Interview on 3/11/25 with the Program Manager revealed:
- Called and told Staff #4 to remove himself from the incident with FC #3 on 12/17/24;
- Seen the frustration with Staff #4 and spoke with him in the moment and afterwards about the use of the Ukeru mat;
- "There was no excuse for not retraining him (Staff #4);"
- Staff #4 should have been retrained in the use of the Ukeru mats;
- Staff #4 could have used de-escalation retraining for dealing with clients in the moment;
- Completed debriefing with Staff #3, Staff #4 and Staff #5, but didn't know why Staff #6 was not included in the debriefing

Interview on 3/11/25 with the Director of Operations revealed:
- Did not review the video surveillance of the incident on 12/17/24 with FC #3 until it was requested by the Division Health Service Regulations surveyor;
- Was informed about the incident by the

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Program Manager after debriefing with the staff involved;
- Due to the information provided by the Program Manager, " I didn't see a need to investigate" the incident with FC #3 on 12/17/24;
- Attended debriefings with the Program Manager and staff when on site and an incident occurs;
- After review of the video surveillance (incident 12/17/24), "the team did a good job checking on each other;"
- "They (staff) could use some training in de-escalation instead of going back and forth with the door because the client could have put her hands down and been hit by the door."

Review on 3/11/25 of the Plan of Protection dated and written on 3/11/25 by the Director of Operations revealed:
- "What immediate action will the facility take to ensure the safety of the consumers in your care?
-Managers debriefed with staff immediately following the incident.
-All staff completed Ukeru training (which includes de-escalation techniques) in the months of December 2024 and January 2025.
-All staff will be trained on 1:1 observations and de-escalation techniques by providing possible scenarios and how to handle these by 4/4/25.
-Describe your plans to make sure the above happens.
-Managers (Program Manager, Director of Operations, Crisis & Nurse Manager, Crisis) will continue to complete the Weekly Monitoring tool onsite, which includes site walk throughs, feedback in real time, support on the floor for scenarios , video monitoring, checking in with patients.
-Monthly Staff meeting to review de-escalation techniques and possible scenarios.

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V 536	Continued From page 19 -Director of Operations, Crisis or designee to review video footage of all incidents." The facility served clients with diagnoses of Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Post Traumatic Stress Disorder, Generalized Anxiety Disorder and Disruptive Mood Dysregulation Disorder ranging in age 12-17 years. On 12/17/24, there was an incident where FC #3 was trying to close her bedroom door. Staff #4 failed to deescalate the situation by pushing on the bedroom door four times while FC #3 was behind the door. FC #3 attempted to hit Staff #4. Staff #4 used the Ukeru mat by pushing FC #3 with the mat. Staff #4 did not receive any retraining on how to properly use alternative interventions. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients and must be corrected within 45 days.	V 536		