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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 4-7-25. The complaint was substantiated (Intake# NC00228303). 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 3 and has a current census of 3. They survey sample consisted of audits of 3 current clients.	V 000		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client.	V 132		

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e. Fraud against a health care facility or against a patient or client for whom the employee is providing services).
Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure Health Care Personnel Registry (HCPR) was notified of an allegation against facility staff, failed to protect the clients while the investigation was in process and failed to report the results of the investigation within five working days of the investigation. The findings are:

Review on 3-17-25 of the North Carolina Incident Response Improvement System (IRIS) from December 1, 2024 to March 17, 2025 revealed:
- No documentation of a March 4, 2025 incident of staff #1 abusing client #2 by hitting client #2 in the nose causing client #2's nose to bleed and of staff #1 forcing client #2 to exercise by running in the facility backyard until client #2 was at the point of exhaustion then forcing client #2 to crawl on his stomach, arms and knees across the backyard causing scrapes and scratches to the back of client #2's forearms.

Review on 3-21-25 of the facility's incident reports from December 1, 2024, to March 17, 2025 revealed:
- Incident Report: dated 3-4-25, 4:30pm, signed by staff #3: Client name [client #2];
-"Incident Description- At 4:30 on March 4, 2025. [client #2] came down the hall after being in a

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room with [staff #1]. He (client #2) informed me (staff # 3) that [staff #1] had hit him in the nose, causing it to bleed.
Immediate action taken I provided [client #2] with tissue and instructed him to sit down in the chair. I gave [client #2] tissue to stop the bleeding and had him tilt his head back. Persons Notified: [Operations Manager]"
-Incident Report: dated 3-4-25, 6:00pm, signed by staff #1: Client name [client #2];
-"Incident Description- Staff (staff #1) was called to go + check on [client #2] because of his behavior, [client #2] had beat on a little girl on the bus with a belt + his shoes because she threaten to hit him if he did not move. Staff (staff #1) warned [client #2] if he has another incident of fighting he would have to exercise as consequence. Immediate action taken: Staff (staff #1) had sat + talked with client (client #2) about his numerous incidents he been having. Staff saw the client (client #2) nose began bleeding during conversation in kitchen with multiple staff (staff #2 and #3) on scene (at the facility). [client #2] just stood abrupt + let his nose bleed after causing it to bleed from digging in his nose. Person Notified: [Director of Operations] 7pm."

Interview and observation on 3-17-25 at 3:15pm with Client #1 revealed:
-Staff has never gotten physical with him. "I don't get in trouble." but he has witnessed staff #1 get physical with client #2.
-"[Client #2] got home from school. They (school) reported a behavior (client #2 hit a fellow student while on the bus 3-4-25) and staff (staff #1) was upset."
-As a consequence of client #1's behavior (hitting a fellow student) on the bus on 3-4-25, staff #1 made client #2 do "work outs" which consisted of

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running back and forth in the backyard.
-"He (staff #1) was trying to use consequences (making client #2 run laps in the backyard) and the peer (client #2) wasn't listening to staff (staff #1), so staff forced him (client #2) to crawl up the hill, over the rocks and dirt and stuff (grass). I mean he (client #1) was on punishment and the punishment was to do work outs."
-"No that was not the first time (work outs were used as a punishment). "They (staff) all do it, it's a consequence (to negative behavior).
-Client #1 went outside and began to exercise with client #2 to encourage client #2 because client #2 was struggling with doing the exercises.
-"So, at first, I was inside (the facility), then I heard him (staff #1) yelling (at client #2) so I went outside. At first, I was just watching. [client #2] was running but then he (staff #1) kept yelling and cursing at [client #2]. He (client #2) was saying he couldn't do it (the exercises), he couldn't breathe. He (client #2) would stop (running) and kind of fall to the ground."
-"He (staff #1) was saying stuff to him (client #2), yelling for him to get up and keep running. [client #2] was telling him (staff #1) he needed to stop and rest and [staff #1] was like mocking him. Saying, 'OOH, I need to rest' (staff #1 was mocking client #2 in a whiny crying voice)."
-"So then I went back in the house (facility) and I put my shoes and socks on and went back outside and he (client #2) was on the ground crawling so I got down there (on the ground) with [client #2] and crawled with him. To show him how to do it."
-"I did it because I wanted to. I wasn't on punishment. I was trying to help [client #2] out.
-"Yeah, he (staff #1) was cursing (at client #2)."
-"Why? What difference does it make (what the exact curse words were)? They (staff) all do (curse around clients)."

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V 132	Continued From page 4 -Two other staff (staff #2 and staff #3) were present in the facility and witnessed the incident on 3-4-25 but failed to intervene. -"Yeah, the two that are in there now (staff #2 and #3) were here (staff #2 and staff #3 witnessed the incident on 3-4-25). They (staff #2 and staff #3) weren't doing anything, they were just saying like, 'why is he doing that (making client #2 to exercise) and stuff like that." -"I think it (the exercise) stopped when [Associate Professional/AP] came. I don't know, he just came, I guess to check on things." Interview on 3/17/25 with client #2 revealed: -"[Staff #1], last week me and him got into it (had a altercation)." -"He (staff #1) has some consequences that are inappropriate. Like he makes us do football drills (exercises). He (staff #1) makes us (clients) run (laps) up and down the yard. I can't do that (run). I can't hardly do one of those (one lap in the yard)." -"I have asthma. I use to have an inhaler (for asthma) but I don't anymore. I couldn't breathe and I stopped running. He yelled at me and said get your 'a*s back here.' I told him (staff #1), 'man I can't breathe. I'm trying to catch my breath.'" -"He (staff#1) was cursing at me, 'get your a*s up, move your fat a*s' and yelling, telling me to get up, get up." -"If you (clients) don't get up when he tells you to, he (staff #1) gives us like 5 seconds, then if we don't get up he grabs our shirt and pulls us up by our shirts. Yeah, he grabbed me like 3 times and was yelling at me to get up." -Client #2 gestured by pulling at the front collar of his shirt and making an upward motion. -"He (staff #1) threw me down (to the ground) a couple of times, and drug me on the ground."	V 132		

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V 132	Continued From page 5 -[Staff #3] was out there (in the backyard). She was like 'OOH,' because she seen him (staff #1) throw me on the ground." -"Yes, I'm scared of him (staff #1). No I don't feel safe with him." -"The other staff are ok. I don't have a problem with any of the other staff, just [staff #1]." -"When I first got here (admitted to the facility), we (client #2 and staff #1) got along good. I was getting in trouble a lot (in school) and he got tired of picking me up from school. He told me, he said I'm tired of picking your ass up every day." Interview on 3/17/25 with client #3 revealed: -Staff #1 had gotten physical with him (unknown dates). -"He (staff #1) pushed me down and dragged me across the ground. I don't know twice, more than twice, a lot of times. No, I didn't cry, that was [client #2]. " -He (staff #1) made [client #2] cry and he made him bleed too. On his lip and his nose. -"He (client #2) had got in trouble at school and [staff #1] was mad at him. He (staff #1) made him do exercise and [client #2] didn't want to (exercise)." -Clients were forced to do exercise as a punishment for bad behavior. -"Yeah, all the time (staff #1 makes them exercise as punishment). No, only [staff #], (makes the clients exercise as punishment). -"You have to run like back and forth (in the yard), then you have to crawl on the ground until he tells you to stop. I don't know, for a long time. Like hours (how long staff #1 makes the clients exercise). All the time (clients are forced to exercise as punishment). -Yeah, I went out there, (outside and witnessed client #2 exercising) but I didn't exercise I went back in the house (facility).	V 132		

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V 132	Continued From page 6 "-[Staff #2] and [staff #3] was here, and [AP] came." -"I don't know (what made staff #1 stop), I think because [AP] came and made him (staff #1) stop." Interview on 3-17-25 with Staff #1 revealed: -Worked one on one with client #2. On 3-4-25 he was notified via the faciliy's group chat that client #2 had gotten into trouble in school and was being defiant with the staff on shift (staff #2 and #3). -"I was called to the group home (facility) for his (client #2), basically a reinforcement, like help (to assist staff #2 and staff #3) ..." -" When he (client #2) got home (facility) he was cursing and going back and forth (arguing) with the staff. He (client #2) doesn't want to do what he is supposed to do (afternoon routine). He's bucking up (being defiant) at staff (staff #2 and staff #3) trying to play hard with the female staff ..." -"So I get there (facility), he (client #2) was upset, but he was more or so upset because he knows he is in trouble (because of the incident with his peer on the bus). With the female staff he doesn't typically do what he is told unless there is a male staff there. So me being the male staff, I talk to him. I figure out what's wrong with him, I process with him. I tried to sit down with him. He basically didn't really want to listen. So we, I have a way (a protocol). I tell them (clients) to go outside, and they have to exercise were basically they do like football drills, you know normal pushups and laps and stuff like that, just to give them air so they can calm down. So that they don't do anything else to mess up the rest of their day. And prior, (before client #2 went outside to exercise) [client #2's] nose had started bleeding ... "	V 132		

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V 132	Continued From page 7 -"After cleaning [client #2] up (cleaned up nosebleed) and making sure that he was all situated we (staff #1, #2, #3) got him back outside and his nose began bleeding again. I helped him clean up. I cleaned his nose up and made sure he was alright. After that it was really just exercise after that. Him (client #2) just doing laps, that's really all that happened that day. -Client #2's nose was not bleeding as he was running. "He (client #2) has excessive nose bleeds so it's common for him to have nose bleeds. I just think what happened before he must have went into the bathroom, or snuck off and went into his room and dug in his nose and made it bleed because when he came back the first thing that he said was that his nose was bleeding and that he didn't want to do the exercise ..." -"And so basically, I helped clean him up and I told him that you can either do this or do that, and he insisted on going outside and doing the exercise verses the alternative which was paperwork ..." -"So we (staff #1, #2 #3) helped him get cleaned up and everything and made sure everything was all right and then [client #2] just became lazy and didn't want to do anything after that. He started saying he wanted to go home, wants to go here, he wants to go there, and just complaining back and forth ..." -"No he did not tell me that he couldn't breath." -Denied cursing at client #2. -Denied yelling at client #2. "No, Ma'am, I have a loud voice, I'm just like my father where I have a very loud voice, I'm very speakative, I'm loud in general. My voice carries so it wasn't that I was yelling, I was not yelling, I just have a loud voice. Plus, we were outside." -Denied aggressively pulling client #2 from the ground after client #2 fell to the ground. "Yes	V 132		

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ma'am, when he kept falling over I was helping him back up, making sure he would stand back up because he would just lay down on the ground and I didn't want him to lay down there and be dirty so I would help him back up."
-"He was on the ground in the grass. He would cry and roll around and I would tell him 'you can't do that.' 'You are going to hurt yourself,' and I would help him up because he would insist on staying on the ground to prevent from doing the exercise."
-Denied forcing client #2 to crawl across the yard on his hands, knees and stomach.
-"Yes, ma'am, So what that is, that is like a little exercise where they (clients) would crawl. They (clients) run, they crawl, they go back and forth (in the yard), and he (client #2) was participating with other clients as well (client #1 was exercising with client #2). They (client #1 and client #3) came out to show support for [client #2] as well because he was having a hard time doing the exercise. All the clients actually came out to show support, to help him you know feel better about the situation. And they (client #1 and client #3) did it (running and crawling) with no problem. They love doing it. It's mainly football exercises.."
-"Yes, I used the exercise as a consequence due to his (client #2) behavior at school (3-4-25) and for his behaviors prior to that day too and yes because he was also having trouble with the staff (staff #2 and staff #3) that was on board (on shift) that day that was already there."
-"[Client #2] never expressed any distress. More so that he didn't want to do the exercise anymore. because at first he was all for it (exercising) saying how tough he was, he was saying, 'I got it, I can handle it,' and then the minute he got out there, he got winded, got tired, fell over and then didn't want to do it (exercise). I was more supporting him, telling him you know, you can do

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V 132	Continued From page 9 it ...basically coaching him." Interview on 3-17-25 with Staff #2 revealed: -She came on shift at approximately 2:30pm on 3-4-25. "When I came in I went straight to the office to count the med (medications) ..." -"I was standing at the desk counting the meds and I happened to see him (client #2) run past the window. I didn't think anything about it, they do exercise sometimes, that's not uncommon." -"When I finished (counting the meds), I came back up front, I think I was going to let [staff #3] know I was about to start dinner and she wasn't in the kitchen. I saw her (staff #3) out back so I stepped outside to see what was going on. When I went outside, he (client #2) was running up and down the yard. No, nothing inappropriate. When I saw him (client #2), he was just running back and forth. [Staff #1] told him to move a little bit faster." -Denied staff #1 yelled or cursed at client #2. "No, I didn't hear him (staff #1) curse. His voice was a little loud because we (staff #1,#2, #3 and client #2) were outside and [client #2] was running so his voice was a little loud but I wouldn't say he was yelling." -Denied seeing staff #1 put his hands on client #2. "No, I didn't see anything like that. The only thing I saw was, there was some blood on the walkway. I thought, 'oh he (client #2) must have had another nosebleed.' Yeah it was a lot of blood. He has nosebleeds. He had had a nosebleed earlier (3-4-25). I went back in the house (facility) and got some bleach and came back and me and [staff #3] cleaned up the blood. After we cleaned up the blood I came back inside and started to prepare dinner. I didn't go back outside after that." -"No, I wasn't concerned because I really didn't see anything." -I started my shift at 2:30 and they were already	V 132		

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out there (staff #1 and client #2 were already in the backyard). They came back in the house right at dinner time. Yeah it was at dinner because as soon as he came in he came to the table and sat down and ate dinner. We eat dinner between 5pm and 6pm . I think it was about 5:30pm that day (3-4-25)."
-Denied any knowledge of any other staff being physical with any other client.

Interview on 3-17-25 with Staff #3 revealed:
-"[Staff #1] had him (client #2) in his bedroom, I guess talking to him about what happened at school that day. They were in there about 15 minutes."
-"I was coming down the hallway towards the office and [client #2] was coming out of his bedroom. He had his hand over his nose and as we were passing each other in the hallway he said '[staff #3], [staff #1] hit me in the nose and made my nose bleed.' When he said that, I thought to myself, oh [client #2], come on now, [staff #1] hit you, really?' I thought he was just making something up. I took him to the bathroom and had him sit down. I gave him some tissue and told him to hold his head back. It was bleeding a lot. It took a while for it to stop bleeding. I remember I had to keep giving him tissue and giving him tissue before we finally got it to stop bleeding."
-"After his nose stopped bleeding [staff #1] took him outside. He made him run and when he couldn't run any longer, he made him crawl. "
-"So he made him start at the top (by the tree line at the top of a slight hill on the far corner of the facility) and he ran to the bottom just to the neighbor's yard (approximately 75 to 100 yards)."
-"He (client #2) didn't like it (having to run), he was complaining. He would stop (running) and say he couldn't breathe. He would sit down on the

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ground and [staff #1] pulled him up by his shirt."
-Yes, he was yelling, telling him (client #2) to keep running. No, I didn't hear him curse. He was just telling him to keep running. "
-"I wasn't out there the whole time. I kept going in and out. It was hard to watch. I couldn't stay out there long and watch it. He was struggling."
-"Yeah, when he (client #2) stopped and couldn't go on running, he (staff #1) made him crawl. Through the yard. Yeah in the grass, the dirt, over the rocks and sticks and things in the yard."
-"Yeah he had some blood on his arms and some scratches and scrapes on the back of his fore arms."
-"I don't (why she did not intervene and stop the interaction between staff #1 and client #2).
-"I told [Human Resources staff] the following day (3-5-25).

Interview on 3-24-25 with the AP revealed:
-Came by the facility on 3-4-25 as part of his duties. "I was just checking on things, seeing how the clients were doing, checking on the staff. When I got out of the car and as I was coming up the driveway I heard [staff #1] talking to [client #2]. I don't know if I would say he was yelling, but he was talking very loud. I was concerned because we are in a neighborhood. It's an older neighborhood, its quite so I didn't want the neighbors to get concerned and call the police or nothing like that. You know, they (neighbors) know this is a group home (facility), I just didn't want there to be any issues. So, I went to the back and just told him, 'hey man lower your voice some, you are talking too loud."
-[Client #2] was running. No, he didn't appear to be in any sort of distress. He wasn't complaining. He wasn't having any issues breathing or anything. At one point he came up to me and spoke. I noticed he had something on his face

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and nose, and I asked him what was on his face. He said he had a nosebleed. I went in the house after that."
-No to his knowledge staff #1 had not had any issues with any of the clients. "No, they never complained about [staff #1]. They all loved [staff #1]."
-No, no one (staff #2 or staff #3) expressed any concern regarding [staff #1] or [client #2] while he was there.

Interviews on 3-17-25 and 3-21-25 with the Qualified Professional (QP) revealed:
-She was informed of the 3-4-25 incident approximately a week later on 3-13-25.
-She called the Chief Executive Officer/Licensee (CEO) immediately as the accused staff is the son of the CEO and Director of Operations/Licensee (DO).
-"I called him in [staff #1] and asked him about the incident. He denied anything happened and I told him to write me a statement."
-"Yes, he was suspended (3-13-25). He was on vacation from 3-5-25 (planned vacation) to 3-13-25 and he didn't work. The day he came back to work from his vacation he came over here (to the facility), I stopped him and told he could not be here. He has not worked with [client #2] since 3-4-25."
-QP had not received the statement from staff #1 as of 3-17-25.
-CEO/Licensee and DO/Licensee was responsible for completing the internal investigation.

Interview on 3-24-25 with the CEO/Licensee revealed:
-She was informed of the 3-4-25 incident by the QP but can't remember the exact date. "It was a day before you showed up. I remember [QP]

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V 132	Continued From page 13 coming to me and telling me about the situation and then the next day you all showed up." -"When she (QP) told me about it (the allegation that staff #1 had abused client #2), everyone knows that [staff #1] is my son, that is no secret. So, in order to keep everything on the up and up I told [QP] that she was the supervisor so she needed to do what she needed to do (start an investigation). She (QP) brought him (staff #1) in (3-14-25) and we (QP and CEO/Licensee) both interviewed him. He told us his side of the story. Being his mother and knowing the person that he is I know that he did not touch that kid (client #2). That is just not [staff #1]. All these kids (clients) love him." -We (CEO/Licensee and QP), did suspend him, we told him that day (3-14-25) that he could not work with [client #2] any longer." -"No there was no reporting to HCPR or North Carolina Incident Response Improvement System (IRIS) because nothing happened, we were looking into a nothing, a rumor. This is his livelihood, his reputation. I'm not going to put someone on the registry over something that can't be proved." -"Well I didn't know that you had to report the allegation. I thought that you reported it after it was substantiated."	V 132		
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	V 366		

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of individuals involved in the incident;
(2) determining the cause of the incident;
(3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;
(4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;
(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;
(6) adhering to confidentiality requirements 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

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internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:
(A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;
(B) gather other information needed;
(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

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V 366	Continued From page 16 for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to implement written policies governing their response to level II incidents. The findings are: Review on 3-17-25 of the North Carolina Incident Response Improvement System (IRIS) from December 1, 2024, to March 17, 2025 revealed: - No level II incident report for 3-4-25 that documented staff #1 forcing client #2 to run the length of the backyard to the point of exhaustion then forcing client #2 crawl on his hands, stomach and knees across the yard causing scrapes and scratches on the back of his forearms. Review on 3-21-25 of the facility's records from December 1, 2024, to March 17, 2025, revealed -No documentation to support the 3-4-25 incident involving client #2 had been evaluated to: -Attend to the health and safety needs of the individual involved in the incident. -Determine the cause of the incident. -Develop and implement corrective measures according to provider specified timeframes not to	V 366		

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exceed 45 days.
-Develop and implement measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days.
-Assign person(s) to be responsible for implementation of the corrective and preventative measures.

Interview on 3-21-25 with the Qualified Professional (QP) revealed:
- "We (staff) didn't do incident reports for the nosebleeds. We will start documenting them (nosebleeds)."
- Staff that witnessed the incident completed the incident reports.
-Chief Executive Officer/Licensee (CEO) or Director of Operations/Licensee is responsible for reporting to IRIS.

Interview on 3-25-25 with the CEO/Licensee revealed:
-She was informed of the 3-4-25 incident by the QP but can't remember the exact date. "It was a day before you showed up. I remember [QP] coming to me and telling me about the situation and then the next day you all showed up (3-13-25).
-"No there was no reporting to the Health Care Personnel Registry or IRIS because nothing happened, we were looking into a nothing, a rumor. This is his (staff#1) livelihood, his reputation. I'm not going to put someone on the registry over something that can't be proved."
-"Well I didn't know that you had to report the allegation. I thought that you reported it after it was substantiated."

This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.

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V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the 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	V 367		

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unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).
(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall 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

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V 367	Continued From page 20 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 all critical incidents in the Incident Response Improvement System (IRIS) and notify the Local Management Entity (LME)/Managed Care Organization (MCO) responsible for the catchment areas where services were provided within 72 hours of becoming aware of the incident. The findings are: Review on 3-17-25 of IRIS from December 1, 2025, to March 17, 2025, revealed: -No level II incident report documenting the allegation that staff #3 hit client #2 in the nose causing client #2's nose to bleed on 3-4-25. -No level II incident report documenting the allegation that staff #1 made client #2 run in the backyard to the point of exhaustion, then staff #2 made client #2 crawl across the backyard on his hands, stomach and knees causing scrapes and scratches on the back of his forearms. Interview on 3/21/25 with the Qualified Professional (QP) revealed: -Chief Executive Officer/Licensee (CEO) or Director of Operations/Licensee completed IRIS reports. Interview on 3-25-25 with the CEO revealed:	V 367		

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V 367	Continued From page 21 -She was made aware of the allegations about a week after the incident (approximately 3-13-25). -"No there was no reporting to the Health Care Personnel Registry or IRIS because nothing happened, we were looking into a nothing, a rumor. This is his (staff #1) livelihood, his reputation. I'm not going to put someone on the registry over something that can't be proved." -"Well I didn't know that you had to report the allegation. I thought that you reported it after it was substantiated." This deficiency constitutes a deficiency and must be corrected within 30 days.	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:	V 500		

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V 500	Continued From page 22 (1) any restrictive intervention that is 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.	V 500		

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V 500	Continued From page 23 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure all incidents of alleged abuse were reported to the County Department of Social Services (DSS). The findings are: Review on 3-21-25 of the facility's record revealed: -No documentation to support County DSS notification for the 3-4-25 incident where client #2 was abused by staff #1 when staff #1 forced client #2 to run in the backyard to the point of exhaustion. Then staff #1 forced client #2 to crawl across the backyard on his hands, stomach and knees causing scrapes and scratches on the back of his forearms. Staff #2, staff #3 and the Associate Professional failed to protect client #2 during the 3-4-25 incident of abuse. Review on 3-17-25 of the Incident Response Improvement System (IRIS) revealed: -No documentation of a report made to the local DSS regarding staff #1 abusing client #2 when staff #1 forced client #2 to run in the backyard to the point of exhaustion. Then staff #2 forced client # 2 to crawl across the backyard on his hands, stomach and knees causing scrapes and scratches on the back of his forearms. Staff #2, staff #3 and the AP failing to protect client during the incident of abuse on 3-4-25. Interview on 3-21-25 with the Qualified Professional (QP) revealed: -The Chief Executive Officer/Licensee or the Director of Operations is responsible for notifying DSS of allegations of abuse. Interview on 3-24-25 with the CEO revealed: -She was informed of the 3-4-25 incident by the	V 500		

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V 500	Continued From page 24 QP but can't remember the exact date. "It was a day before you showed up. I remember [QP] coming to me and telling me about the situation and then the next day you all showed up (3-13-25)." -"No there was no reporting to the Health Care Personnel Registry or IRIS because nothing happened, we were looking into a nothing, a rumor. This is his (staff #1) livelihood, his reputation. I'm not going to put someone on the registry over something that can't be proved." -"Well I didn't know that you had to report the allegation. I thought that you reported it after it was substantiated."	V 500		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree 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	V 512		

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V 512	Continued From page 25 (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, observation and interviews 1 of 4 audited staff (staff #1) abused 3 of 3 clients (client #1, #2, #3) and 3 of 4 audited staff (staff #2, staff #3 and the Associate Professional (AP)) failed to protect 3 of 3 clients (client #1, #2, #3). The findings are: Review on 3-17-25 of client #1's record revealed: -Date of admission: 8-5-24. -Age: 14 years. -Diagnoses: Autism; Attention Deficit Hyperactivity Disorder (ADHD); Learning Disability; Reactive Attachment Disorder; Disruptive Mood Dysregulation Disorder. Review on 3-17-25 of client #2's record revealed: -Date of admission: 1-7-25. -Age: 12 years. -Diagnoses: ADHD, combined presentation; Autism Spectrum Disorder; Unspecified Trauma and Stressor Related Disorder. Review on 3-17-25 of client #3's record revealed: -Date of admission: 10-18-24. -Age: 11 years. -Diagnoses: Post-Traumatic Stress Disorder, unspecified; ADHD. Interview and observation on 3-17-25 at 3:15pm with Client #1 revealed: -Staff never hit or put their hands on him. -Client #1 witnessed staff #1 punish client #2 by forcing client #2 to exercise by running laps and	V 512		

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to crawl on the ground over rocks, dirt and the grass.
-"[Client #2] got home from school. They (school) reported a behavior (client #2 hit a fellow student while on the bus 3-4-25) and staff (staff #1) was upset."
-As a consequence of client #2 hitting a fellow student on the bus on 3-4-25, staff #1 made client #2 do "work outs" which consisted of running back and forth in the backyard. When client #2 could not run any longer, staff #1 forced client #2 to crawl up a hill, over rocks, dirt and grass.
-"He (staff #1) was trying to use consequences and the peer (client #2) wasn't listening to staff (staff #1), so staff forced him (client #2) to crawl up the hill, over the rocks and dirt and stuff (grass). I mean he (client #2) was on punishment and the punishment was to do work outs."
-That was not the first time work outs were used as a punishment. "They (staff) all do it, it's a consequence (to negative behavior)."
-Client #1 went outside and began to exercise with client #2 to encourage client #2 because client #2 was unable to run the length of the yard.
-"I did it because I wanted to. I wasn't on punishment. I was trying to help [client #2] out."
-"So, at first, I was inside (the facility), then I heard him (staff #1) yelling (at client #2) so I went outside. At first, I was just watching. [Client #2] was running but then he (staff #1) kept yelling and cussing at [client #2]. He (client #2) was saying he couldn't do it (the exercises), he couldn't breathe. He (client #2) would stop (running) and kind of fall to the ground."
-"He (staff #1) was saying stuff to him (client #2), yelling for him to get up and keep running. [client #2] was telling him (staff #1) he needed to stop and rest and [staff #1] was like, mocking him. Saying, 'OOH, I need to rest.'"
-"So then I went back in the house (facility) and I

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V 512	Continued From page 27 put my shoes and socks on and went back outside and he (client #2) was on the ground crawling so I got down there (on the ground) with [client #2] and crawled with him. To show him how to do it." -"He (staff #1) was cussing (at client #2)." -"Why? What difference does it make (what the exact curse words were)? They (staff) all do (curse around clients)." -"The two that are in there now (present in the facility) were here (staff #2 and staff #3 witnessed the incident on 3-4-25). They (staff #2 and staff #3) weren't doing anything, they were just saying like, 'why is he doing that (making client #2 to exercise) and stuff like that." -"I think it (the exercise) stopped when [AP] came. I don't know (why AP came), he just came, I guess to check on things." Interview and observation on 3/17/25 with client #2 revealed: -"[Staff #1], last week me and him got into it (staff #1 hit client #2 in the nose causing a nosebleed. Then forced client #2 to exercise as a form of punishment)." -"He (staff #1) has some consequences (punishments) that are inappropriate. Like he makes us do football drills (exercises). He (staff #1) makes us (clients) run (laps) up and down the yard. I can't do that (run). I can't hardly do one of those (one lap in the yard)." -"I have asthma. I use to have an inhaler (for asthma) but I don't anymore. I couldn't breathe and I stopped running. He yelled at me and said get your 'a*s back here. I told him (staff #1), 'man I can't breathe. I'm trying to catch my breath.'" -"He (staff# 1) was cussing at me, 'get your a*s up, move your fat a*s' and yelling, telling me to 'get up, get up.'" -Client #2 stopped running and fell to the ground	V 512		

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V 512	Continued From page 28 3 times in order to try to catch his breath. Staff #1 grabbed client #2 by the collar of his shirt and pulled him from the ground. "He grabbed me like 3 times and was yelling at me to get up." -Observed client #2 gesture by pulling at the front collar of his shirt and making an upward motion. -"He (staff #1) threw me down (to the ground) a couple of times, and drug me on the ground." -[Staff #3] was out there (in the backyard). She was like 'OOH,' because she seen him (staff #1) throw me on the ground." -"Yes, I'm scared of him (staff #1). No I don't feel safe with him." -He (staff #1) hit me on my nose. In the room (bedroom). It hurt, yeah, my nose started bleeding." -"The other staff are ok. I don't have a problem with any of the other staff, just [staff #1]." -"When I first got here (admitted to the facility), we (client #2 and staff #1) got along good. I was getting in trouble a lot (in school) and he got tired of picking me up from school. He told me, he said 'I'm tired of picking your a*s up every day.'" Interview on 3/17/25 with client #3 revealed: -Staff #1 pushed him down and drug him on the ground (unknown dates). -"He (staff #1) pushed me down and dragged me across the ground. I don't know twice, more than twice, a lot of times. No, I didn't cry, that was [client #2]. " -He (staff #1) made [client #2] cry and he made him bleed too. On his lip and his nose. -"He (client #2) had got in trouble at school and [staff #1] was mad at him. He (staff #1) made him do exercise and [client #2] didn't want to (exercise)." -Clients were made to do exercise as a punishment for bad behavior. -Staff #1 makes clients exercise as punishment.	V 512		

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"All the time."
-"You have to run like back and forth (in the yard), then you have to crawl on the ground until he tells you to stop. I don't know for a long time, like hours (how long staff #1 makes the clients exercise). All the time (clients are made to exercise as punishment)."
-"Yeah, I went out there, (outside and witnessed client #2 exercising) but I didn't exercise I went back in the house."
"-[Staff #2] and [staff #3] was here, and [AP] came."
-Staff #1 is the only staff that uses exercise as punishment.
-"I don't know (what made staff #1 stop), I think because [AP] came and made him (staff #1) stop."

Interview on 3-17-25 with Staff #1 revealed:
-Worked one on one with client #2. On 3-4-25 he was notified via the faciliy's group chat that client #2 had gotten into trouble in school and was being defiant with staff #2 and #3.
-"I was called to the group home (facility) for his (client #2), basically a reinforcement, like help (to assist staff #2 and staff #3) ..."
-" When he (client #2) got home (facility) he was cursing and going back and forth (arguing) with the staff. He (client #2) doesn't want to do what he is supposed to do (afternoon routine). He's bucking up (being defiant) at staff (staff #2 and staff #3) trying to play hard with the female staff ..."
-"So I get there (facility), he (client #2) was upset, but he was more or so upset because he knows he is in trouble (because of the incident with his peer on the bus). With the female staff he doesn't typically do what he is told unless there is a male staff there. So me being the male staff, I talk to him. I figure out what's wrong with him, I

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process with him. I tried to sit down with him. He basically didn't really want to listen. So we, I have a way. I tell them (clients) to go outside, and they have to exercise where basically they do like football drills, you know normal pushups and laps and stuff like that, just to give them air so they can calm down. So that they don't do anything else to mess up the rest of their day. Prior, (before client #2 went outside to exercise) [client #2's] nose had started bleeding. It had just started bleeding. We (staff #1, #2, #3 and client #2) were all grouped up in the kitchen talking amongst ourself about the situation (client #2's behavior) and his nose began bleeding..."
-Denied hitting client #2 in the nose causing his nose to bleed.
-"After cleaning [client #2] up (cleaned up nosebleed) and making sure that he was all situated we (staff #1, #2, #3) got him back outside and his nose began bleeding again. I helped him clean up. I cleaned his nose up and made sure he was alright. After that it was really just exercise after that. Him (client #2) just doing laps, that's really all that happened that day.
-Client #2's nose was not bleeding as he was running. "He (client #2) has excessive nose bleeds so it's common for him to have nose bleeds. I just think what happened before (in the facility) he must have went into the bathroom, or snuck off and went into his room and dug in his nose and made it bleed because when he came back the first thing that he said was that his nose was bleeding and that he didn't want to do the exercise ..."
-"And so basically, I helped clean him up and I told him that you can either do this or do that, and he insisted on going outside and doing the exercise versus the alternative which was paperwork ..."
-"So we (staff #1, #2 #3) helped him get cleaned

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up and everything and made sure everything was all right and then [client #2] just became lazy and didn't want to do anything after that. He started saying he wanted to go home, wants to go here, he wants to go there, and just complaining back and forth ..."
-"No he did not tell me that he couldn't breath."
-Denied cursing at client #2.
-Denied yelling at client #2. "No, Ma'am, I have a loud voice...I'm loud in general. My voice carries so it wasn't that I was yelling, I was not yelling, I just have a loud voice. Plus, we were outside."
-Denied aggressively pulling client #2 from the ground after client #2 fell to the ground. "Yes ma'am, when he kept falling over I was helping him back up, making sure he would stand back up because he would just lay down on the ground and I didn't want him to lay down there and be dirty so I would help him back up."
-"He was on the ground in the grass. He would cry and roll around and I would tell him 'you can't do that.' 'You are going to hurt yourself,' and I would help him up because he would insist on staying on the ground to prevent from doing the exercise."
-Denied forcing client #2 to crawl across the yard on his hands, knees and stomach.
-"Yes, ma'am, So what that is, that is like a little exercise where they (clients) would crawl. They (clients) run, they crawl, they go back and forth (in the yard), and he (client #2) was participating with other clients as well (client #1 was exercising with client #2). They (client #1 and client #3) came out to show support for [client #2] as well because he was having a hard time doing the exercise. All the clients actually came out to show support, to help him you know feel better about the situation, and they (client #1 and client #3) did it (running and crawling) with no problem. They love doing it. It's mainly football exercises.."

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-"Yes, I used the exercise as a consequence due to his (client #2) behavior at school (3-4-25) and for his behaviors prior to that day too and yes because he was also having trouble with the staff (staff #2 and staff #3) that was onboard (on shift) that day that was already there."
-"[Client #2] never expressed any distress. More so that he didn't want to do the exercise anymore. Because at first he was all for it (exercising) saying how tough he was, he was saying, 'I got it, I can handle it,' and then the minute he got out there, he got winded, got tired, fell over and then didn't want to do it (exercise). I was more supporting him, telling him you know, you can do it ...basically coaching him."

Interview on 3-17-25 with Staff #2 revealed:
-She came on shift at approximately 2:30pm on 3-4-25. "When I came in I went straight to the office to count the med (medications) ..."
-"I was standing at the desk counting the meds and I happened to see him (client #2) run past the window. I didn't think anything about it, they do exercise sometimes, that's not uncommon."
-"When I finished (counting the meds), I came back up front, I think I was going to let [staff #3] know I was about to start dinner and she wasn't in the kitchen. I saw her (staff #3) out back so I stepped outside to see what was going on. When I went outside, he (client #2) was running up and down the yard. No, nothing inappropriate. When I saw him (client #2), he was just running back and forth. [Staff #1] told him to move a little bit faster."
-Denied staff #1 yelled or cursed at client #2. "No, I didn't hear him (staff #1) curse. His voice was a little loud because we (staff #1,#2, #3 and client #2) were outside and [client #2] was running so his voice was a little loud but I wouldn't say he was yelling."
-Denied seeing staff #1 put his hands on client

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#2. "No, I didn't see anything like that. The only thing I saw was, there was some blood on the walkway. I thought, 'oh he (client #2) must have had another nosebleed.' Yeah it was a lot of blood. He has nosebleeds. He had had a nosebleed earlier (3-4-25). I went back in the house (facility) and got some bleach and came back and me and [staff #3] cleaned up the blood. After we cleaned up the blood I came back inside and started to prepare dinner. I didn't go back outside after that."
-"No, I wasn't concerned because I really didn't see anything."
-"I started my shift at 2:30 (pm) and they were already out there (staff #1 and client #2 were already in the backyard). They came back in the house right at dinner time. Yeah it was at dinner because as soon as he came in he came to the table and sat down and ate dinner. We eat dinner between 5(pm) and 6(pm) . I think it was about 5:30 (pm) that day (3-4-25)."
-Denied any knowledge of any other staff hitting or putting hands on other client.

Interview on 3-17-25 with Staff #3 revealed:
-"[Staff #1] had him (client #2) in his bedroom, I guess talking to him about what happened at school that day (3-4-25). They were in there about 15 minutes."
-"I was coming down the hallway towards the office and [client #2] was coming out of his bedroom. He had his hand over his nose and as we were passing each other in the hallway he said '[staff #3], [staff #1] hit me in the nose and made my nose bleed.' When he said that, I thought to myself, oh [client #2], come on now, [staff #1] hit you, really?' I thought he was just making something up. I took him to the bathroom and had him sit down. I gave him some tissue and told him to hold his head back. It was

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bleeding a lot. It took a while for it to stop bleeding. I remember I had to keep giving him tissue and giving him tissue before we finally got it to stop bleeding."
-"After his nose stopped bleeding [staff #1] took him outside. He (staff #1) made him run and when he couldn't run any longer, he made him crawl. "
-"So he made him start at the top (by the tree line at the top of a slight hill on the far corner of the facility) and he ran to the bottom just to the neighbor's yard (approximately 75 to 100 yards)."
-"He (client #2) didn't like it (having to run), he was complaining. He would stop (running) and say he couldn't breathe. He would sit down on the ground and [staff #1] pulled him up by his shirt."
-"He (staff #1) was yelling, telling him (client #2) to keep running. "I didn't hear him curse. He was just telling him to keep running. "
-"I wasn't out there the whole time. I kept going in and out. It was hard to watch. I couldn't stay out there long and watch it. He (client #2) was struggling."
-When client #2 could not continue to run staff #1 made him crawl through the yard. Client #2 crawled in the dirt, and grass, over rocks and sticks causing the back of his forearms to get scratched and scraped and bleed.
-Staff #3 could not state why she failed to intervene in the incident. "I don't know."
-"I told [Human Resources staff] the following day (3-5-25).

Interview on 3-24-25 with the AP revealed:
Came by the facility on 3-4-25 as part of his duties. "I was just checking on things, seeing how the clients were doing, checking on the staff. When I got out of the car and as I was coming up the driveway I heard [staff #1] talking to [client #2]. I don't know if I would say he was yelling, but

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he was talking very loud. I was concerned because we are in a neighborhood. It's an older neighborhood, its quiet so I didn't want the neighbors to get concerned and call the police or nothing like that. You know, they (neighbors) know this is a group home, I just didn't want there to be any issues. So, I went to the back and just told him, 'hey man lower your voice some, you are talking too loud."
-[Client #2] was running. No, he didn't appear to be in any sort of distress. He wasn't complaining. He wasn't having any issues breathing or anything. At one point he came up to me and spoke. I noticed he had something on his face and nose, and I asked him what was on his face. He said he had a nosebleed. I went in the house after that."
-No to his knowledge staff #1 had not had any issues with any of the clients. "No, they never complained about [staff #1]. They all loved [staff #1]."
-Staff #2 or staff #3 did not express any concern regarding [staff #1] or [client #2] while he was there.

Interviews on 3-17-25 and 3-21-25 with the Qualified Professional (QP) revealed:
She was informed of the 3-4-25 incident approximately a week later on 3-13-25.
-She called the Chief Executive Officer/Licensee (CEO/Licensee #1) immediately as the accused staff is the son of the CEO and Director of Operations/Licensee #2 (DO/Licensee #2).
-"I called him in [staff #1] and asked him about the incident. He denied anything happened and I told him to write me a statement."
-"Yes, he was suspended (3-13-25). He was on vacation from 3-5-25 to 3-13-25 and he didn't work. The day he came back to work from his vacation he came over here (to the facility), I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601499	A. BUILDING: _____ B. WING _____	R 04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLABORATIVE HOPE-SKYVIEW	1101 SKYVIEW ROAD CHARLOTTE, NC 28208

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V 512	Continued From page 36 stopped him and told he could not be here. He has not worked with [client #2] since 3-4-25." -The QP had not received the statement from staff #1 as of 3-17-25. Interview on 3-24-25 with the CEO/Licensee #1 revealed: -She was informed of the allegations by the QP but can't remember the exact date, but believes the date to be 3-14-24. When she (QP) told me about it, everyone knows that [staff #1] is my son, that is no secret. So, in order to keep everything on the up and up I told [QP] that she was the supervisor so she needed to do what she needed to do (start an investigation). She (QP) brought him (staff #1) in and we (QP and CEO/Licensee #1) both interviewed him. He told us his side of the story. Being his mother and knowing the person that he is I know that he did not touch that kid (client #2). That is just not [staff #1]. All these kids (clients) love him." -We (CEO/Licensee #1 and QP), did suspend him (3-14-25), we told him that day that he could not work with [client #2] any longer." -Staff #1 continued to work at the sister facility at another location. Review on 4-4-25 of the facility's Plan of Protection dated 4-4-25 and signed by the CEO/Licensee revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? 1. [Staff #1's] termination has already taken place from Skyview (facility) home once the allegations were logged. 2. All staff will be retrained in alternatives to restrictive interventions. 3. All staff will be retrained in crisis identification response and management.	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601499	A. BUILDING: _____ B. WING _____	R 04/07/2025

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COLLABORATIVE HOPE-SKYVIEW	1101 SKYVIEW ROAD CHARLOTTE, NC 28208

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V 512	Continued From page 37 4. All staff will be trained in management of the disruptive behaviors of the population served. Describe your plans to make sure the above happens. 1. [Staff #1] was terminated from Skyview (facility) work assignment on 3-14-2025 as a plan initiated to ensure that steps were taken that the members involved in this event as well as the other residents are reassured, they will be safe, [staff #1] was terminated from the Skyview (facility) work assignment on 3-14-2025 as part of a plan to reassure members and residents that they will be safe and free from harm while receiving care at Skyview (facility) home in [local county]. free from harm while care is provided by staff at the Skyview (facility) home-[local county]. He was not terminated from the Company and will receive weekly Supervision from the Qualified Professional for ongoing/training and education. 2. An absolute decision has been made by the leadership/supervisory team that [staff #1] is not to have any current and future engagement nor contact with any members of the Skyview Home site. The Qualified Professional has along with the CEO, to ensure this does not occur. This information has been provided to [staff #1], and he acknowledges this rule. Skyview supervisors are on site, on call to monitor as required and to report any violation of this rule. 3. The Qualified Professional will assess the members ' perception of safety in the next 7 days of this dated plan and again within the following 3 weeks. 4. Crisis identification response and management; All staff training will occur by 4-10-2025. 5.	V 512		

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V 512	Continued From page 38 All staff will be retrained in alternatives to restrictive interventions by 4-15-2025." The facility served clients ranging from 11 years to 14 years old with diagnoses such as Post Traumatic Stress Disorder, Attention Deficit Hyperactivity disorder, Oppositional Defiant Disorder, Autism Spectrum Disorder, and Unspecified Trauma and Stressor Related Disorder. As a consequence to bad behavior, staff #1 used exercise as a form of punishment. On 3-4-25 as a consequence for client #2 hitting one of his school peers on the school bus earlier that day, client #2 reported staff #1 hit him in his nose causing his nose to bleed and later forced him to exercise from approximately 2:30pm to 5:30pm. Client #2 was forced to run the length of the facility backyard which was approximately 75-100 yards. Client #2 ran until he was out of breath and fell to the ground 3 times in an effort to catch his breath at which time staff #1 grabbed client #2 by the collar of his shirt and pulled him off the ground. Staff #1 continued to yell and curse and when client #2 could no longer run, Staff #1 made client #2 crawl causing his arms to bleed. Staff #2, #3 and the Associate Professional were present at the facility during all or part of the incident and failed to intervene. This deficiency constitutes a Type A1 rule violation for abuse and neglect and must be corrected within 30 days.	V 512		