

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL079-125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/09/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THE DOVE HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>911 BERRYMORE ROAD</b> <b>REIDSVILLE, NC 27320</b>
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V 000	<p><b>INITIAL COMMENTS</b></p> <p>A complaint survey was completed on 9/9/25. The complaint was unsubstantiated (intake #NC00232927). Deficiencies were cited.</p> <p>This facility is licensed for the following service category 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.</p> <p>This facility is licensed for 6 and has a current census of 4. The survey sample consisted of audits of 1 former client.</p>	V 000		
V 318	<p><b>13O .0102 HCPR - 24 Hour Reporting</b></p> <p>10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g).</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility failed to notify Health Care Personnel Registry (HCPR) within 24 hours of learning about</p>	V 318		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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V 318	<p>Continued From page 1</p> <p>allegations of abuse affecting 1 of 1 Staff (Former Staff #1). The findings are:</p> <p>Review on 9/2/25 of former staff (FS) #1's personnel record revealed: -Hire date: 1/2/24. -Date of Separation: 7/12/25. -Job Title: Direct Support Professional.</p> <p>Review on 9/3/25 of the facility records revealed: -There was no HCPR 24 hour Initial Report for the allegation of abuse of former client #1 for incident on 7/12/25. -There was a HCPR thank you letter for reporting (FS #1) dated 7/24/25.</p> <p>Review of North Carolina Incident Response Improvement System (IRIS) for incident on 7/6/25 (correct date 7/12/25) revealed: -HCPR Level II was completed for incident on 7/12/25 for improper restraint. -On 7/15/25 Local Management Entity reviewed report and recommended the incident was a Level III. -The facility completed Level III information for 7/12/25 incident on 7/15/25.</p> <p>Interview on 9/3/25 with the Qualified Professional revealed: -She was responsible for inputting the IRIS report. -Was made aware of the incident on 7/12/25. -Had completed the IRIS report for 7/12/25 incident with correction on 7/15/25. - "They [facility staff] did not give me the paperwork until 7/14/25", "put it in as a level 2 and the reviewer seen it as a level 3." -"When we [facility management] first reviewed it [video of incident on 7/12/25] we were thinking improper restraint and not abuse."</p>	V 318		

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V 366	<p>27G .0603 Incident Response Requirements</p> <p>10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</p> <p>(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:</p> <ol style="list-style-type: none"> <li>(1) attending to the health and safety needs of individuals involved in the incident;</li> <li>(2) determining the cause of the incident;</li> <li>(3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;</li> <li>(4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;</li> <li>(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;</li> <li>(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</li> <li>(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.</li> </ol> <p>(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.</p> <p>(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:</p>	V 366		

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V 366	<p>Continued From page 3</p> <p>(1) immediately securing the client record by:</p> <p>(A) obtaining the client record;</p> <p>(B) making a photocopy;</p> <p>(C) certifying the copy's completeness; and</p> <p>(D) transferring the copy to an internal review team;</p> <p>(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:</p> <p>(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;</p> <p>(B) gather other information needed;</p> <p>(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</p> <p>(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</p>	V 366		

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V 366	<p>Continued From page 4</p> <p>LME may give the provider an extension of up to three months to submit the final report; and</p> <p>(3) immediately notifying the following:</p> <p>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;</p> <p>(B) the LME where the client resides, if different;</p> <p>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;</p> <p>(D) the Department;</p> <p>(E) the client's legal guardian, as applicable; and</p> <p>(F) any other authorities required by law.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement written policies governing their response to Level III incidents as required. The findings are:</p> <p>Review on 9/2/25 of former client (FC) #1's record revealed: -Admission date: 6/18/25. -Discharge date: 8/13/25. -12 years old. -Diagnoses: Oppositional Defiant Disorder and Attention Deficit Hyperactivity Disorder. -Comprehensive Clinical Assessment dated 5/23/25 - "The client [former client #1] (FC #1) has been living with his aunt on his father's side for several months now. Since living there his</p>	V 366		

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V 366	<p>Continued From page 5</p> <p>behavior has not significantly escalated but remains troubled and problematic. There have been at least two instances where he was found with a knife, he has gotten suspended from school several times, at least once for fighting. He has been absent from school on numerous occasions. There are ongoing concerns about possible substance use, but there has not been confirmation of this. The client is now involved with the Juvenile Justice system and has a court counselor, but no court date yet ..."</p> <p>Review on 9/4/25 of an in-house incident report revealed: -7/12/25-"Staff #2 told [former client (FC) #1] to stop threatening (FS #1) and stop calling (former staff (FS) #1) out of their name. (FS #1) told (FC #1) how disrespectful that is and how we need to find better way to express his (FC #1) anger ...." -The facility reported that the incident ended in an improper restraint by (FS #1).</p> <p>Review on 9/3/25 of North Carolina Incident Response Improvement System (IRIS) for incident on 7/6/25 (correct date 7/12/25) revealed: -Level II report was completed for incident on 7/12/25 for an improper restraint. -There was no Level III incident reports submitted by the facility for the incident on 7/12/25. -On 7/15/25 the Local Management Entity/Managed Care Organization (LME/MCO) reviewed the report and recommended the incident was a Level III. -The facility completed Level III information for 7/12/25 incident on 7/15/25.</p> <p>Review on 9/3/25 of the facility's initial documentation for the incident on 7/12/25 of revealed:</p>	V 366		

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V 366	<p>Continued From page 6</p> <ul style="list-style-type: none"> <li>-No documentation of attending to the health and safety needs of the FC #1 on 7/12/25.</li> <li>-No documentation of determining the cause of the incident on 7/12/25.</li> <li>-No documentation of developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days.</li> <li>-No documentation of assigning person (s) to be responsible for implementation of the corrections and preventative measure.</li> </ul> <p>Interview on 9/3/25 with the Qualified Professional revealed:</p> <ul style="list-style-type: none"> <li>-Was aware of the incident on 7/12/25 with FC #1 and FS #1.</li> <li>-Was not aware of the time requirement that an allegation of abuse required.</li> <li>-"When we [facility management] first reviewed it [video of incident on 7/12/25] we were thinking improper restraint and not abuse."</li> <li>-He, (FS #1) had been terminated on 7/12/25 after his shift ended at 7pm.</li> </ul>	V 366		
V 367	<p>27G .0604 Incident Reporting Requirements</p> <p>10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</p> <p>(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</p>	V 367		

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V 367	<p>Continued From page 7</p> <p>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:</p> <p>(1) reporting provider contact and identification information;</p> <p>(2) client identification information;</p> <p>(3) type of incident;</p> <p>(4) description of incident;</p> <p>(5) status of the effort to determine the cause of the incident; and</p> <p>(6) other individuals or authorities notified or responding.</p> <p>(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:</p> <p>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or</p> <p>(2) the provider obtains information required on the incident form that was previously unavailable.</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(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</p>	V 367		

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V 367	<p>Continued From page 8</p> <p>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:</p> <ol style="list-style-type: none"> <li>(1) medication errors that do not meet the definition of a level II or level III incident;</li> <li>(2) restrictive interventions that do not meet the definition of a level II or level III incident;</li> <li>(3) searches of a client or his living area;</li> <li>(4) seizures of client property or property in the possession of a client;</li> <li>(5) the total number of level II and level III incidents that occurred; and</li> <li>(6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.</li> </ol> <p>This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to report all level III incidents to the Local Management Entity (LME)/Managed Care Organization (MCO) in the catchment area within</p>	V 367		

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V 367	<p>Continued From page 9</p> <p>72 hours of becoming aware of the incident. The findings are:</p> <p>Review on 9/2/25 of former client (FC) #1's record revealed: -Admission date: 6/18/25. -Discharge date: 8/13/25. -12 years old. -Diagnoses: Oppositional Defiant Disorder and Attention Deficit Hyperactivity Disorder.</p> <p>Review on 9/4/25 of an in-house incident report revealed: -7/12/25-"Staff #2 told (former client (FC) #1) to stop threatening former staff #1 (FS #1) and stop calling (FS #1) out of their name. (FS #1) told (FC #1) how disrespectful that is and how we need to find better way to express his (FC #1) anger ...." -The facility reported that the incident was an improper restraint completed by (FS #1).</p> <p>Review of North Carolina Incident Response Improvement System (IRIS) for incident on 7/6/25 (correct date 7/12/25) revealed: -Level II report was completed for incident on 7/12/25 for improper restraint on 7/14/25. -There was no Level III incident report submitted by the facility for the incident on 7/12/25. -On 7/15/25 Local Management Entity/Managed Care Organization (LME/MCO) reviewed the report and recommended the incident was a Level III. -The facility completed Level III information for 7/12/25 the incident on 7/15/25.</p> <p>Interview on 9/3/25 with the Qualified Professional revealed: -Was aware of the incident on 7/12/25 with (FC #1) and (FS #1). -Was not aware of the time requirement that an</p>	V 367		

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V 367	Continued From page 10  allegation of abuse required. -"When we [facility management] first reviewed it [video of incident on 7/12/25] we were thinking improper restraint and not abuse." -He, FS #1 had been terminated on 7/12/25 after his shift ended at 7pm.	V 367		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect  10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.  This Rule is not met as evidenced by: Based on record reviews, interviews, and	V 512		

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V 512	<p>Continued From page 11</p> <p>observations, 1 of 1 audited former staff (former staff (FS) #1) abused 1 of 1 former client (FC #1) and 2 of 3 audited staff (#2, #3) neglected 1 of 3 clients (FC #1). The findings are:</p> <p>Review on 9/2/25 of former staff #1's personnel record revealed: -Hire date: 1/2/24. -Date of Termination: 7/12/25. -Job Title: Direct Support Professional. -A training certificate in Nonviolent Crisis Intervention dated 1/3/25.</p> <p>Review on 9/4/25 of staff #2's personnel record revealed: -Hire date: 3/10/24. -Job Title: Direct Support Professional. -A training certificate in Nonviolent Crisis Intervention dated 3/7/25.</p> <p>Review on 9/4/25 of staff #3's personnel record revealed: -Hire date: 11/23/24. -Job Title: Direct Support Professional. -A training certificate in Nonviolent Crisis Intervention dated 11/22/24.</p> <p>Review on 9/2/25 of FC #1's record revealed: -Admission date: 6/18/25. -Discharge date: 8/13/25. -12 years old. -Diagnoses: Oppositional Defiant Disorder and Attention Deficit Hyperactivity Disorder. -Comprehensive Clinical Assessment dated 5/23/25 - "[FC #1] has been living with his aunt on his father's side for several months now. Since living there his behavior has not significantly escalated but remains troubled and problematic. There have been at least two instances where he was found with a knife, he has gotten suspended</p>	V 512		

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V 512	<p>Continued From page 12</p> <p>from school several times, at least once for fighting. He has been absent from school on numerous occasions. There are ongoing concerns about possible substance use, but there has not been confirmation of this. The client is now involved with the Juvenile Justice system and has a court counselor, but no court date yet ..."</p> <p>Review on 9/2/25 of a Level III incident report for FC #1 dated 7/6/25 (date entered in error by the facility) for incident which occurred on 7/12/25 and was submitted on 7/14/25 in the North Carolina Incident Response Improvement System (IRIS) revealed:</p> <ul style="list-style-type: none"> <li>-The date and time of the incident: 7/12/25 at 5:22pm.</li> <li>-Identified as a Level II IRIS for improper restraint on 7/14/25.</li> <li>-7/15/25 - Local Management Entity/Managed Care Organization (LME/MCO) reviewer recommended for Level II to be increased to Level III with reporting to HCPR (Health Care Personnel Registry) of alleged abuse/neglect.</li> </ul> <p>Review on 9/2/25 of the facility's in-house intervention Advisory Committee/Human Rights Committee's report dated 7/14/25 for the incident on 7/12/25 revealed:</p> <ul style="list-style-type: none"> <li>-"An incident between [FS #1], and [FC #1], occurred on 7.12.25 at the Dove House group home located at 911 Berrymore Rd. Reidsville, NC 27320, around 5:22 PM.</li> <li>[FC #1] had been displaying disrespectful behaviors and was verbally abusive to [FS #1] all day. This incident began when a [FS #1], turned the TV off and took the remote in the kitchen as he was preparing dinner. [FC #1] became very upset and walked into the kitchen to get the remote back and turned the TV back on. When</li> </ul>	V 512		

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V 512	<p>Continued From page 13</p> <p>[FS #1] tried to verbally prompt him to give the remote back, it turned into a verbal power struggle. [FC #1] got up from the couch and moved towards the kitchen island. At this point [FS #1], continued to prompt him to give the remote control up. [FS #1] got in [FC #1] face, posturing. [FC #1] stated, 'I'm about to beat his a*s with this stool.' [FS #1] appeared to be agitated putting both hands around [FC #1's] neck forcefully moving him towards the kitchen area and ended up laying him on his back on the deep freezer. [FS #1] then lifted him down to the ground restraining his arms. [FS #1] was able to get the remote control back. [FS #1] released the restraint. The [FC #1] got up from the floor and walked into the living room and sat on the couch. [FS #1] walked outside and contacted the Program Manager and did not have any further contact with the [FC #1]. [FS #1] left at 7:00 PM. The Program Manager contacted the Chief Executive Officer (CEO) to inform her of the situation and the internal investigation began. The (CEO) told Program Manager based on what is being reported, [FS #1] would most likely need to be terminated. The Program Manager immediately contacted the child's (FC #1's) guardian to inform of the incident. The Program Manager also checked on the [FC #1] to check on his mental and physical status. [FC #1] did not report any pain, distress or injury. After reviewing the video footage, the executive team decided to immediately terminate [FS #1] due to not following proper protocols regarding restraints nor proper treatment of [FC #1]."</p> <p>Observation on 9/3/25 of the facility at 1:52pm revealed: -Measurements of the space between the couch in the living room and the small deep freezer were approximately 11.5 feet.</p>	V 512		

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V 512	<p>Continued From page 14</p> <p>Review on 9/3/25 of a video recorded by the facility of the 7/12/25 incident revealed:</p> <ul style="list-style-type: none"> <li>-Video was approximately 4 minutes and 45 seconds long.</li> <li>-Incident began in the living room area of the facility.</li> <li>-FS #1 and FC #1 argued over the TV remote.</li> <li>-FS #1 had gone over to the couch where FC #1 sat with the TV remote and asked for the TV remote.</li> <li>-FS #1 stood and leaned over FC #1 while FC #1 was in a seated position on the couch, and repeatedly asked for the TV remote.</li> <li>-FC #1 got up from the couch and stood directly in front of FS #1.</li> <li>-Staff #3 at this time stood in front of FC #1 and beside FS #1. Staff #2 observed the interaction in the kitchen, on the other side of the kitchen island approximately 3 feet away.</li> <li>-FS #1 gave repeated verbal prompts to FC #1 to hand him the remote.</li> <li>-FS #1 had then lowered his face to be directly in FC #1's face and stated, "hand her (staff #3) the remote."</li> <li>-FC #1 with both arms pushed FS #1 in the upper stomach area backwards away from him and stated he would "beat [FS #1] a*s with a chair."</li> <li>-FS #1 picked up a bar stool, backless tall stool located next to him and motioned to hand it to FC #1, prompting FC #1 to hit him ....'here!'</li> <li>-At 5:24:23PM, FC #1 did not take the bar stool and FS #1 slammed the bar stool down on the floor next to staff #2.</li> <li>-At 5:24:24 PM, FS #1 placed one hand in front of FC #1's front part of neck around throat area and the other hand was on the back of FC #1's neck and choked FC #1 with both of his hands in a tight choke grip.</li> <li>-FS #1 forced FC #1 to move backwards with his</li> </ul>	V 512		

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V 512	<p>Continued From page 15</p> <p>hands still on FC #1's neck and continued to choke FC #1 for approximately 1.5 seconds.</p> <p>-Staff #3 backed away from FS #1 while he pushed FC #1 approximately 2 feet towards the kitchen area away from the living room area.</p> <p>-At 5:24:26 PM, FS #1 removed his hands from around FC #1's neck and with his hands grabbed FC #1's shoulders on both sides to push and move and forced FC #1 to move towards the small deep freezer in the kitchen approximately 38 inches wide, 34 inches high continued to push and force FC #1 approximately 11.5 feet from the living room into the kitchen to the small deep freezer.</p> <p>-FS #1 with his hands picked up FC #1 by his upper arms and shoved him backside down on top of the deep freezer and with FS #1's arms and body FS #1 held and pushed FC #1 in his upper chest area while FS #1 held FC #1 down on top of the freezer for several seconds.</p> <p>-At 5:24:32 Staff #2 and staff #3 were approximately an arm's length from FC #1 and FS #1. Neither Staff #2 or staff #3 intervened verbally or physically while FS #1 abused FC #1.</p> <p>-At 5:24:39 PM, FS #1 lifted and pulled and removed FC #1 off the top of the freezer by FC #1's upper arms and shoulders and shoved him down on to the kitchen floor.</p> <p>-At 5:24:44 - 5:24:51PM, FS #1 straddled over FC #1 and held him down on the floor, and held both of FC #1's arms into his chest area with FS #1's upper body, applied pressure and force onto FC #1's upper body and chest area.</p> <p>-At 5:24:54 PM, staff #3 drank from a cup and watched FS #1 hold and push into FC #1 while straddled over him on the floor.</p> <p>-At 5:24:57 PM, staff #2 turned her back and walked away from FC #1 while FS #1 was straddled over FC #1 and held and pushed repeatedly into FC #1's chest area and upper</p>	V 512		

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V 512	<p>Continued From page 16</p> <p>body while on the floor.</p> <p>-At 5:25:01 PM, on the kitchen floor FS #1 released his hold from FC #1's arms and stood up. Staff #2 told FC #1 to go to his room. -FC #1 went and sat on the couch, and FS #1 walked to and sat at a desk in the kitchen area for approximately 30 seconds, then FS #1 got up and went out the front door of the facility. End of the video recording.</p> <p>Interview on 9/5/25 with FC #1 revealed:</p> <p>-FS #1, "Put his hands around my neck and tried to choke me ....it (being choked by FS #1) went from the living room to the freezer in the kitchen."</p> <p>-"I don't remember everyone that was there, only know [FS #1 and staff #2]."</p> <p>-"She (staff #2) was just kinda of sitting there watching."</p> <p>-When asked if Staff #2 said anything to FS#1 while FS #1 hands were around his neck and choked him, "no, he [FS #1] was just choking me."</p> <p>-He did not get physically hurt when he was choked by FS #1.</p> <p>-Only staff #2 and staff #3 were present inside the facility when FS #1 choked him.</p> <p>Interview on 9/3/25 with FC #1's Department of Social Services Guardian revealed:</p> <p>-The facility informed her on 7/14/25 of the abuse that occurred to FC #1 on 7/12/25.</p> <p>Attempted interviews on 9/2/25 and 9/3/25 with FS #1 revealed:</p> <p>-Did not return phone calls by exit of the survey process.</p> <p>Interview on 9/2/25 and 9/3/25 with staff #2 revealed:</p> <p>- "...it (abuse by FS #1 on FC #1) all happened so</p>	V 512		

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V 512	<p>Continued From page 17</p> <p>quick. I don't really honestly understand how it escalated."</p> <p>- When asked if she did or did not respond or intervene when FS #1 choked FC #1 on 7/12/25, " no, I was in shock, it went from A - Z so quick, it was a learning experience."</p> <p>Interview on 9/2/25 and 9/3/25 with staff #3 revealed: -She was in "shock" the incident happened so fast, on 7/12/25 when FS #1 abused FC #1. - "I don't know what was said, he [FS #1] yoked him up (grabbed FC #1 by the shoulders by the neck) by the time I spun around the client (FC #1) was on the ground." -"I was stuck in one spot." -"I told [FS #1] to calm down," After the incident, when FC #1 was no longer choked by FS #1.</p> <p>Interview on 9/3/25 with the Crisis Prevention Institute (CPI) Instructor with the program of Nonviolent Crisis Intervention revealed: -"We deescalate first and move things out the way, then physical restraint is the last resort." -Had reviewed the video of the incident on 7/12/25 at the facility "no authorized restraints that were used during this incident" on 7/12/25. -When asked about teaching choke holds in restraint training, "absolute not," to restrain using choke holds.</p> <p>Interview on 9/2/25 and 9/3/25 with the Program manager revealed: -He knew about the choking incident done by FS #1 on FC #1 immediately from staff #2 on shift when staff #2 called him and reported it. -He had reviewed the facility video footage of the incident on 7/12/25 at approximately 5:30pm or 6pm. -"I observed a staff member [FS #1] lost control at</p>	V 512		

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V 512	<p>Continued From page 18</p> <p>that moment." -He (FS #1) was not around clients for the rest of shift, for approximately 1 hour and 30 min. -He had terminated FS#1 that day after his shift ended at 7pm on 7/12/25.</p> <p>Interview on 9/2/25 and 9/3/25 with the Qualified Professional revealed: -There were 4 staff working on the day of the incident, 3 staff were inside the facility, FS #1, staff #2 and staff #3. -The FC #1 had a doctor's appointment on 7/14/25 for general check up that was scheduled prior to the incident, no bruising or cuts from the incident on 7/12/25 was located. -Completed the IRIS report on 7/14/25 when all the information was gathered from staff that were present for the abuse incident.</p> <p>Review on 9/5/25 of the Plan of Protection dated 9/5/25 and written by the Qualified Professional revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? [Licensee] will do the following: continue to monitor clients in the home. Continued training with staff with de-escalation skills, tap out, mandatory reporting in IRIS. Utilize and review the client's Crisis Plan. Policy review. Staff, [staff #2 and staff #3], will no longer be on schedule until internal investigation is completed.</p> <p>Describe your plans to make sure the above happens. -Complete internal investigation. -CSTP (Crisis Stabilization Transition Program) Leadership meeting with Program Director, Program Manager, Case Manager, and Therapist scheduled for September 8th at 1pm. -Staff department meeting scheduled for</p>	V 512		

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V 512	<p>Continued From page 19</p> <p>September 10th @ 10am -Mandatory ongoing trainings with dates scheduled: Policy review, Documentation review, Other training as needed determined by leadership, management, or staff. "</p> <p>Review on 9/9/25 of the Plan of Protection dated 9/9/25 and written by the Qualified Professional revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? [Licensee] will do the following: continue to monitor clients in the home using the camera log observation, check in, and note review. Continued training with staff with de- escalation skills, tap out, mandatory reporting in IRIS. Utilize and review the client's crisis plan. Policy review. Documentation review. Staff, [staff #2] and [staff #3], will no longer be on schedule until the HCPR (Health Care Personnel Registry) is resolved and /or A1 appeal with an unsubstantiated determination. Filing incident report [staff #2] and [staff #3] for the incident on July 12, 2025 and the HCPR for both on 9/9/25.</p> <p>Describe your plans to make sure the above happens. -Complete internal investigation. -CSTP (Crisis Stabilization Transition Program) Leadership meeting with Program Director, Program Manger, Case Manager, and Therapist scheduled for September 8th at 1pm. -CSTP meeting with Leadership on September 9, 2025 at 3pm. -Mandatory ongoing trainings with dates scheduled: Policy review: Abuse and Neglect, Clients Rights, Alternative to Restrictive Interventions/De-escalation, Code of Ethical Conduct, Incident reporting. Documentation review: Notes, IRIS report. Other training as</p>	V 512		

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V 512	<p>Continued From page 20</p> <p>needed determined by leadership, management, or staff."</p> <p>This facility served a 12 year old FC #1 who was diagnosed with Oppositional Defiant Disorder and Attention Deficit Hyperactivity Disorder. On 7/12/25, FS #1 abused FC #1 when FS #1 choked FC #1. FS #1 placed one hand in front of FC #1's front part of his neck around his throat area and the other hand was on the back of FC #1's neck and choked FC #1 with both of his hands in a tight grip choke.</p> <p>FS #1 forced FC #1 backwards with his hands still on FC #1's neck and choked FC #1 for approximately 1.5 seconds.</p> <p>Staff #3 backed away from FS #1 while he pushed FC #1 approximately 2 feet towards the kitchen area away from the living room area.</p> <p>FS #1 removed his hands from around FC #1's neck and grabbed FC #1's shoulders on both sides and pushed and moved and forced FC #1 towards the small deep freezer in the kitchen and pushed and forced FC #1 approximately 11.5 feet from the living room in the kitchen.</p> <p>FS #1 picked up FC #1 by his upper arms and shoved FC #1 backside down on top of the deep freezer and with FS #1's arms, hands and body, FS #1 held and pushed FC #1 in his upper chest area while FS #1 held FC #1 down on top of the freezer for several seconds.</p> <p>FS #1 lifted and pulled and removed FC #1 off the top of the freezer by FC #1's upper arms and shoulders and shoved him down on to the kitchen floor.</p> <p>Staff #2 and staff #3 were approximately an arm's length from FC #1 and FS #1.</p> <p>FS #1 then straddled over FC #1 and held FC #1 down on the floor, while FS #1 straddled over and held both of FC #1's arms into his chest area with his upper body and applied pressure onto FC #1's</p>	V 512		

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V 512	<p>Continued From page 21</p> <p>upper body and chest area onto the floor. Staff #3 drank from a cup and watched FS #1 hold FC #1's arms and push into FC #1 while straddled over him on the floor. Staff #2 turned her back and walked away from FS #1 while he was straddled over FC #1 and held FC #1's arms and pushed into FC #1 upper chest and body while on the floor. FS #1 released his hold from FC #1's arms and stood up. Staff #2 told FC #1 to go to his room. FC #1 went and sat on the couch, and FS #1 walked to and sat at a desk in the kitchen area for approximately 30 seconds, then FS #1 got up and went out the front door of the facility. Staff #2 and Staff #3 neglected FC #1, they did nothing verbally or physically to intervene while FS #1 abused FC #1.</p> <p>This deficiency constitutes a Type A1 rule violation for serious abuse and neglect and must be corrected within 23 days.</p>	V 512		