Division of Health Service Regulation

PRINTED: 04/20/2018 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(XZ) MULTIPLE CONSTRUCTION A. BUILDING:		
		/ · · · · · · · · · · · · · · · · · · ·		s (R
MHL036-287		B. WING	B. WNG		
IAME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
IIRACLE HOUSES - TWIN AVENL	2004 TV	IN AVENUE			
III A DEL TIO DOLO - TIVILI AVEILO	GASTO	NIA, NC 28062			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFÉRENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 000 INITIAL COMMENTS		V 000			
completed on 4/18/18 unsubstantiated (Inta were cited. This facility is license	ke #136488). Deficiencies d for the following service 27G .1700 Residential		Mental Health 93 2018	8 POIT	
V 200 270 .1704 Residential Staffing	d Tx. Child/Adel Min.	1/706			
able to reach the facilitimes. (b) The minimum purifications. (b) The minimum purification one, two, three or four direct one, two, three or four direct on adolescents; and (3) four direct on the adolescents. (c) The minimum num during child or adolescents follows: (1) two direct on and one shall be away children or adolescents.	sional shall be available by a direct care staff shall be lity within 30 minutes at all appears of direct care staff en or adolescents are as follows: are staff shall be present for a children or adolescents; care staff shall be present eight children or are staff shall be present for welve children or or an are staff shall be present for each sleep hours is as are staff shall be present ke for one through four ts; are staff shall be present as a staff shall be present to the form of through four ts; are staff shall be present as the for five through eight		DHSR - Menta MAY 032 Lic. & Cert. S	018	

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	FORM APP	
	IDENTIFICATION NUMBER		A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-287	B. WNG		R	
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS CITY A	DRESS, CITY, STATE, ZIP CODE		
MIRACLE	HOUSES - TWIN AVENU	E 2004 TV	VIN AVENUE	STATE, ZIP CODE		
		GASTO	NIA, NC 28052			
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
TAG	REGULATORY OR L	FICIENCY MUST BE PRECEDED BY FULL DRY OR LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES OF THE APPROPRIES O	D 000	
V 296	Continued From page	1	V 296			
- 1	(3) three direct of	are staff shall be present	1000000			
1	of which two shall be a	Wake and the third may be			1	
	adolescents,	even or twelve children or				
		lnimum number of direct	1		1	
	care starr set forth in P	aragraphs (a)-(c) of this				
- 1	rule, more direct care	staff shall be required in				
- 1	the facility based on the	child or adolescent's				
1	Individual needs as spe plan.	cified in the treatment		1	1	
		e responsible for ansuring				
1 3	supervision of children	or adolescents when they				
1 9	are away from the facilit	V in accordance with the				
	or adolescents ind	lividual strengths and				
1.	needs as specified in the	e treatment plan.				
- 1					1	
	his Pula is action					
В	his Rule is not met as a	nd interviews, the facility				
1 18	illed to ensure the requi	red staff/client ratio. The		The Executive Coordinator will ensu	FO 01/27/27	
fir	ndings are;			that weekly schedule will include tw	re 04/18/20:	
0	bsenietion == 4/4044=			staff at all times when new consume	ers are	
I P	vealed:	t 11:10am at the facility		admitted. Staff will be in ration of tv	VO	
		al (AP) was present with		staff to one consumer in the facility	of	
CII	ent #4;	1		4 beds or less.		
-n	o other staff were prese	nt on site;				
-pe	er the AP, clients #1, #2	and #3 were in school.	1			
Int	erview on 4/16/18 with	client #3 revealed:				
-171	the mornings, one to the	ree staff present.				
-at	munt, one to two staff r	resent.				
-las	st night, only one staff of	recent-				
Sor	third shift, sometimes netimes two staff there.	one staff there,				
	ervice Regulation		1			

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Divisi	on of Health Service Regi	ulation			FORM APPROVED	ł
STATE	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-287	B. WNG		R 04/18/2018	
: NAME C	F PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	TATE ZIP CODE	1 04/10/2018	
MIRAC	LE HOUSES - TWIN AVENU		VIN AVENUE	7,21 0002		
	THE PARTY OF THE P	_	NIA, NC 28052			1
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY DR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP DEFICIENCY)		E COMPLETE		
V 2	Continued From page	2	V 296			I
		vith the licensee revealed: I to AP about having two s; site at all times.				
V 7	52 27G .0304(b)(4) Hot V	Vater Temperatures	V 752			
	EQUIPMENT (b) Safety: Each facility constructed and equipy ensures the physical solutions.	ped in a manner that afety of clients, staff and be facility where clients are the temperature of the				
	the facility where clients water, the temperature maintained between 10 The findings ere: Observation on 4/16/18 -hot water in the kitcher Fahrenheit;	aw, observations and ailed to ensure in areas of swere exposed to hot of the water was 10-116 degrees Fahrenheit. at 2:25pm revealed: a sink was 130 degrees orm sink was 128 degrees ent records revealed: of Attention Deficit ADHD), Histrionic ost Traumatic Strass		The Executive Director will ensure that the Licensed Contractor will ensure that the water temperature at the facility will remain between 100 – 116 degrees. Staff will continue to check the water temperature daily and will notify the Executive Director immediately of temperature above 116 degrees Executive Director will contact Licensed Contractor to immediately check and reduce the temperature of the water.	y	
Islan of He	Disorder (PTSD), Anxiet	bst fraumatic Stress by Disorder, Disruptive		or the water.		

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Division of Health Service Regulation					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL036-287	B. WING		R 04/18/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE	
MIRACLE	HOUSES - TWIN AVENU		N AVENUE IA, NC 28052		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETE
V 752	issues regulating water assessment and treat -client #2 had diagnosmo issues regulating wassessment and treat -client #3 had diagnosmo Disorder and Depress regulating water per attreatment plan. Review on 4/11/18 of 1/1/18-present revealed the hot water temperature was ended in injuries as temperature. Interview on 4/16/18 was professional (AP) revenue aware hot water temperature and checked the hot water temperature and checked the hot water temperature.	Disorder(DMDD) with no er per admission ment plan; sis of ADHD and PTSD with vater per admission ment plan; sis of PTSD, Anxiety ive Disorder with no issues dmission assessment and facility incident reports from ed no injuries as a result of ture. with clients #1, #2 and #3 is a result of the hot water with the Associate ealed: oo hot; is just out a few days ago water and adjusted it; or down immediately. 8 at 3:35pm revealed the	V 752		



7508 E. Independence Blvd Charlotte, NC 28227 (704) 535-4447 – Office (704) 535-4476 – Fax



FAX COVER SHEET

DATE:

May 2, 2018

TO:

Gina McLain

FROM:

Nikki Utsey

SUBJECT:

POC for Miracle Houses – Twin Avenue

MHL 036-287

FAX NO.:

919-715-8078

PHONE NO.:

Message

Waiting on CCA

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THANK YOU!

of pages ____