STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601227	A. BUILDING: _____ B. WING _____	07/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERANCAS COTTAGE	6750 SAINT PETERS LANE, SUITE 300 MATTHEWS, NC 28105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint survey was completed on 7/24/18. The complaint was substantiated (Intake #NC140971). No deficiencies were cited related to the complaint. A deficiency unrelated to the complaint was cited. This facility is licensed for the following survey category: 10A NCAC 27G .1900 Psychiatric Residential Treatment Facility.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112	V 112 Plan of Correction: Residential Therapists will review the Person Centered Plans for all current clients and update the intervention sections for each goal to ensure that restrictive interventions are not noted as a planned intervention. At the last Clinical Team Group Supervision that was held on July 26, 2018, Clinical Manager reviewed the requirement with the staff and they acknowledged understanding of the requirement. All current Person Centered Plans will be checked and corrected if they contain planned Restrictive Interventions by August 15th, 2018. Preventative Measures: At admission, the Clinical Manager and Authorization Specialist will review Person Centered Plans that are received by provider agencies for submission for an initial PRTF authorization to ensure that the interventions do not include planned Restrictive Interventions. Monitoring: Residential Therapists will review the Person Centered Plan every 30 days, and in turn, will review the interventions for each goal so they do not include planned Restrictive Interventions. This will be included on our program monitoring tool that is done each quarter via our Performance and Quality department. DHSR - Mental Health AUG 13 2018 Lic. & Cert. Section	8/15/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Hannah Dunham, VP of Performance + Quality Improvement 8/9/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601227	A. BUILDING: _____ B. WING _____	07/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERANCAS COTTAGE	6750 SAINT PETERS LANE, SUITE 300 MATTHEWS, NC 28105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	Continued From page 1 This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure restraints were not included as a planned intervention in the treatment plans affecting 1 of 3 clients (#3). The findings are: Review on 7/19/18 of client #3's record revealed: -admission date of 2/27/18; -diagnosis of Attention Deficit Hyperactivity Disorder, Intermittent Explosive Disorder, Oppositional Defiant Disorder and Enuresis; -treatment plan dated 1/30/18 with most recent update of 6/14/18 documented restraints could be utilized if client #3 was a danger to himself or others. Review on 7/19/18 of the facility incident reports from 5/1/18-7/24/18 revealed the following: -5/16/18 client #3 was restrained for trying to attack a peer and attacking a staff; -6/27 client #3 was restrained for attacking a peer, punching a window, breaking the glass; -both incidents documented in IRIS as a Level II. Interview on 7/24/18 with the Director of Performance and Quality revealed: -do not use restraints as a planned intervention; -clinicians complete the treatment plans; -have been over this with clinicians repeatedly regarding no planned restrictive interventions in treatment plans; -think there is a template somewhere clinicians are using; -a few new clinicians were hired recently; -will address with the clinicians herself and	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601227	A. BUILDING: _____ B. WING _____	07/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERANCAS COTTAGE	6750 SAINT PETERS LANE, SUITE 300 MATTHEWS, NC 28105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	Continued From page 2 resolve the issue.	V 112		

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

August 8, 2018

Hannah Dunham, Director of Performance and Quality
Thompson Child and Family Focus
6800 Saint Peters Lane
Matthews, NC 28105

Re: Complaint Survey completed July 24, 2018
Merancas Cottage, 6750 Saint Peters Lane, Matthews, NC 28105
MHL # 060-1227
Email: hdunham@thompsoncff.org
Intake #NC140971

Dear Ms. Dunham:

Thank you for the cooperation and courtesy extended during the Complaint survey completed July 24, 2018.The complaint was substantiated. No deficiencies were cited related to the complaint. A deficiency was cited unrelated to the complaint.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- A Standard level deficiency was cited.

Time Frames for Compliance

- Standard level deficiency must be ***corrected*** within 60 days from the exit of the survey, which is September 22, 2018.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records.
Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Lynn Grier at 704-596-4072

Sincerely,

Gina McLain

Gina McLain
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: Rob Robinson, Director, Alliance Behavioral Health LME/MCO
Wes Knepper, Quality Management Director, Alliance Behavioral Health LME/MCO
Trey Sutten, Director, Cardinal Innovations LME/MCO
Onika Wilson, Quality Management Director, Cardinal Innovations LME/MCO
W. Rhett Melton, Director, Partners Behavioral Healthcare LME/MCO
Selenna Moss, Quality Management Director, Partners Behavioral Healthcare LME/MCO
Victoria Whitt, Director, Sandhills Center LME/MCO
Mary Kidd, Quality Management Director, Sandhills Center LME/MCO
Brian Ingraham, Director, Vaya Health LME/MCO
Patty Wilson, Quality Management Director, Vaya Health LME/MCO