


Division of Health Service Regulation

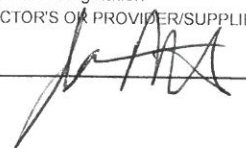
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/04/2019
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NAME OF PROVIDER OR SUPPLIER TURN AROUND	STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, NC 28227
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V 000	<p>INITIAL COMMENTS</p> <p>A complaint survey was completed on 3-4-19. The complaint was substantiated (#NC00148272) Deficiencies were cited.</p> <p>A sister facility is identified in this report. The sister facility will be identified as sister facility A. Sister Facility staff and clients will be identified using the letter of the facility and a numerical identifier.</p> <p>Both the facility and sister facility A are licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Adolescents or Children (Level III) services.</p>	V 000	<p>DHSR - Mental Health</p> <p>APR 26 2019</p> <p>Lic. & Cert. Section</p> <p><i>please see attached</i></p> 	
V 293	<p>27G .1701 Residential Tx. Child/Adol - Scope</p> <p>10A NCAC 27G .1701 SCOPE</p> <p>(a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility.</p> <p>(b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section.</p> <p>(c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services.</p> <p>(d) The children or adolescents served shall require the following:</p> <p>(1) removal from home to a</p>	V 293		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

Executive Director


(X6) DATE

4/8/19

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V 293	<p>Continued From page 1</p> <p>community-based residential setting in order to facilitate treatment; and</p> <p>(2) treatment in a staff secure setting.</p> <p>(e) Services shall be designed to:</p> <p>(1) include individualized supervision and structure of daily living;</p> <p>(2) minimize the occurrence of behaviors related to functional deficits;</p> <p>(3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint;</p> <p>(4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and</p> <p>(5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting.</p> <p>(f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care.</p> <p>This Rule is not met as evidenced by: Based on record reviews, interviews and observation the facility failed to ensure that services were designed to minimize the occurrences of behaviors related to functional deficits effecting 4 of 4 clients (Clients #1, #2,#3, and #4) The findings are:</p> <p>Cross reference 10A NCAC 27G .1704 Minimum</p>	V 293	<p>please see attached</p> 	

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V 293	<p>Continued From page 2</p> <p>Staffing Requirements (V296). Based on record reviews and interviews the facility failed to ensure the minimum number of direct care staff required when clients were in the facility. The findings are:</p> <p>Review on 2-25-19 of client #1's record revealed:</p> <ul style="list-style-type: none"> -Admitted 12-31-18. -10 years old. -Diagnoses of Post Traumatic Stress Disorder (PTSD), Attention Deficit/Hyperactivity Disorder (AD/HD), Oppositional Defiance Disorder, Unspecified Trauma Stressor Related Disorder. -Admission Assessment dated 12-31-18 : "been in several foster placements and disrupted due to unmanageable behavior...goals of decreasing verbal and physical aggression and property damage...requires vigilant adult supervision." -Comprehensive Clinical Assessment addendum dated 7-25-18: displayed homicidal threats, fighting with peers...impulsivity, property damage, lying, lack of focus, poor interactions with other foster children...taunting, teasing others, name calling." -Clinical intake dated 1-29-18: "continues to place dolls in sexual positions, point at genitalia and giggle, sleeping in the nude, and masturbating by rubbing against furniture or self-stimulation...will stop at nothing to create havoc...requires constant supervision in the home due to lack of concern for safety and and impulsive behaviors." -Person Centered Plan dated 11-14-18: "communicated threats to peers...goals include; control agitated behavior and appropriately express anger, will decrease sexualized behavior as evidenced by interacting in a non-sexual manner maintain appropriate boundaries (staff have not observed sexualized behavior)...will 	V 293	<p>please see attached</p> 	
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V 293	<p>Continued From page 3</p> <p>work to maintain composure when things do not go her way..."</p> <p>-Crisis plan includes: give clear, concise instructions, encourage, remind her of her coping skills has helped.</p> <p>Review on 2-25-19 of client #3's record revealed:</p> <p>-Admitted 11-13-18. -15 years old. -Diagnoses include Unspecified Disruptive Impulse Control, Conduct Disorder, Unspecified Trauma and Stressor Reactive Disorder, and moderate cannabis use. -Admission Assessment dated 11-13-18; disrupted foster placement due to elopement, not abiding by the rules of the home or probation. -Diagnostic Assessment dated 3-27-18; ran 3 times in level II foster care. She will use substances when gone...recommend level III. -Person Centered Plan last updated 8-24-18; goals include resolve issues with department of social services placement, elopement and substance abuse, will develop two coping skills for stress, will work toward improving school behaviors, will improve personal hygiene.</p> <p>Review on 2-25-19 of client #4's record revealed:</p> <p>-Admitted 1-26-18. -16 years old. -Diagnoses included: AD/HD, Oppositional Defiance Disorder, and Disruptive Mood Dysregulation Disorder. -Admission assessment dated 1-26-18; "discharged from a psychiatric residential treatment facility...made significant progress...needs to respect adults and use adequate coping skills...attacking mother by kicking her in the stomach requiring stitches...threatening mother and siblings." -Comprehensive Psycho Social addendum</p>	V 293	<p><i>please see Attached</i></p> 	


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V 293	<p>Continued From page 4</p> <p>dated 1-3-18; "behaviors include sneaking, lying property destruction, unwilling to accept responsibility...past two months exponential progress...been engaged in therapy ...begun to process through physical and sexual abuse that occurred in foster home."</p> <p>-Goals include; will comply with adult authority figures...will use anger management to avoid throwing temper tantrum...will take responsibility for her actions.</p> <p>-Crisis Plan included;will act out verbally...give space and supervision...talk in low voice so she does not become defensive.</p> <p>Observation on 2-20-19 at approximately 2:30 pm revealed:</p> <p>-Clients #1,#3, and #4 loudly arguing in the kitchen area. One staff interacting with clients, trying to calm them down. She was listening, talking, and trying to work out a solution to their problem. Clients argued for approximately 5-10 minutes. Staff #1 was reminding clients about their coping skills and encouraging the clients to use them. Facility manager was sitting at the desk, not engaging. DHSR (Division of Health Service Regulation) Surveyor asked the facility manager if she was going to engage, she got up and went in and helped separate the clients. The clients did not engage in a physical altercation.</p> <p>Interview on 2-26-19 with client #3 revealed:</p> <p>-She doesn't think the facility manager ever does anything.</p> <p>-"She doesn't do her job."</p> <p>Interview on 2-27-19 with the Director of Operations revealed:</p> <p>-"You are making a lot of assumptions on a 10 minute observation."</p> <p>-"The kids are always on 20."</p>	V 293	<p>please see attach</p> 	

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V 293	<p>Continued From page 5</p> <p>-"The arguing probably sounds chaotic." -"What looks like chaos to you might not be." -"I don't think that's a fair assumption at all."</p> <p>Plan of Protection dated 2-27-19 and signed by the Executive Director reviewed on 2-27-19 revealed:</p> <p>What will you immediately do to correct the above rule violation in order to protect clients from further risk or additional harm?</p> <p>"The Director of Operations will immediately ensure that the agency remain in compliance with staffing requirements at all times. The Director of Operations will ensure that two staff on shift will follow agency policy by transporting all consumers on all appointments at all times to protect the clients from a risk of an incident occurring with only one staff present in the group home. The Director of operations will ensure that all employees adhere to this policy by signing a written agreement that they will remain on site at all times during scheduled shift."</p> <p>Describe your plans to make sure the above happens.</p> <p>"The Director of Operations will ensure that the two designated employees ([facility manager] & [Staff #8] serve as floaters for all of the group homes to assist with transportation and ensure that the two staff on shift are able to remain at the group home."</p> <p>Client #1 had a history of physical aggression and property damage, and has displayed homicidal threats, fighting with peers, taunting, and teasing others. The facility is currently seeking a higher level of care for her due to her</p>	V 293	<p><i>please see attached</i></p> 	

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V 293	<p>Continued From page 6</p> <p>violent behavior. Client #2 had a history of refusing to follow directions, had a difficult time interacting with peers, and incidents of physical aggression. Client #3's diagnoses included Conduct Disorder, and unspecified trauma and stressor reactive disorder.</p> <p>On 2-3-19 clients #1 and #2 got into a physical altercation, with client #3 joining in. Staff #1 did try to intervene when clients #1 and #2 were fighting but was unable to prevent client #3 from joining in the altercation. Clients reported that Staff #1 was working by herself. No injuries resulted from the altercation. Staff and clients reported that staff sometimes work by themselves on the weekend and at night. The repeated lack of required staffing created an opportunity for clients #1, #2, and #3 to engage in a physical altercation that staff #1 was unable to deescalate. This constitutes an A2 rule violation for substantial risk of harm and must be corrected within 23 days. An administrative penalty of 1,000 dollars is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of 500.00 per per day will be imposed for each day the facility is out of compliance beyond the 23rd day.</p>	V 293	<p>please see Attached</p> 	
V 296	<p>27G .1704 Residential Tx. Child/Adol - Min. Staffing</p> <p>10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS</p> <p>(a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times.</p> <p>(b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows:</p>	V 296		

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V 296	<p>Continued From page 7</p> <p>(1) two direct care staff shall be present for one, two, three or four children or adolescents;</p> <p>(2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and</p> <p>(3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents.</p> <p>(c) The minimum number of direct care staff during child or adolescent sleep hours is as follows:</p> <p>(1) two direct care staff shall be present and one shall be awake for one through four children or adolescents;</p> <p>(2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and</p> <p>(3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents.</p> <p>(d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan.</p> <p>(e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan.</p> <p>This Rule is not met as evidenced by:</p>	V 296	<p><i>please see attached</i></p> 	

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V 296	<p>Continued From page 8</p> <p>Based on record reviews and interviews the facility failed to ensure the minimum number of direct care staff required when clients were in the facility. The findings are:</p> <p>Finding 1</p> <p>Review on 2-25-19 of IRIS (Incident Response Improvement System) report dated 2-5-19 completed by the executive director revealed: -"Date of incident-2-3-19." -"The consumer (client #1) had been antagonizing her peers throughout the shift. As the consumer felt that consumer [client # 2] shut the door in her face she began to use excessive aggression toward [client #2]. Residential Counselor [staff #1] attempted to intervene and directed the consumer to prepare for her nightly hygiene and get ready for bed she (client #1) became more upset and yelled at consumer [client #2] 'that's why your momma is dead'. Consumer [client #2] then grabbed a cup of water and threw it on the consumer and the consumer (client #1) attempted to attack consumer [client #2]. RC (Residential Counselor) [staff #1] intervened and stopped the physical altercation between the two. As RC [staff # 1] was calming consumer [client #2] the consumer (client #1) then began taunting consumer [client #3]. The consumer (client #1) told consumer [client #3] 'that's why your momma is retarded and ratchet' before walking up on consumer [client #3] and pushing her. Consumer [client #3] then hit the consumer several times before RC [staff #1] could separate the two. After RC [staff #1] was able to get [client #3] and [client #2] calmed the consumer (client #1) continued her verbal aggression for several minutes and eventually calmed down."</p>	V 296	<p>please see attached</p> 	

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V 296	<p>Continued From page 9</p> <p>Review on 2-25-19 of IRIS report dated 2-13-19 completed by the executive director revealed: -"Date of incident: 2-3-19." -2-13-19: "...This original incident occurred 02/03/19 and apparently the consumer went to school and told a teacher she had been attacked by two older peers in the group home and staff did nothing about it. This provider submitted the incident reports on the morning of 02/05/19 (within 72 hours) later that afternoon this provider received a call from [county child protective services] (CPS)] informing the provider that a call had been received the facility had allowed the consumer to be beat up by two older peers and staff members did nothing about it. Once the provider went in to update the original PCP from the incident 02/06/19 the report had been closed therefore, this provider completed a new incident report for the allegation." -"Notes from the 2/3/19 incident , 2-13-19: the 2/3/19 incident was downgraded to a level 1, no police contact. The consumer (client #1) had been antagonizing her peers throughout the shift. As the consumer felt that consumer [client #2] shut the door in her face she began to use excessive aggression toward [client #2]. Residential Counselor [staff #1] attempted to intervene and directed the consumer to prepare for her nightly hygiene and get ready for bed she became more upset and yelled at consumer [client #2] 'that's why your momma is dead'. Consumer [client #2] then grabbed a cup of water and threw it on the consumer and the consumer (client #1) attempted to attack consumer [client #2]. RC (Residential Counselor) [staff #1] intervened and stopped the physical altercation between the two. As RC [staff #1] was calming consumer [client #2] the consumer (client #1) then began taunting consumer [client #3]. The consumer (client #1) told consumer [client #3]</p>	V 296	<p>please see attached</p> 	


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V 296	<p>Continued From page 10</p> <p>'that's why your momma is retarded and ratchet' before walking up on consumer [client #3] and pushing her. Consumer [client #3] then hit the consumer several times before RC [staff #1] could separate the two. After RC [staff #1] was able to get [client #3] and [client #2] calmed the consumer (client #1) continued her verbal aggression for several minutes and eventually calmed down."</p> <p>Review on 2-25-19 of undated and unsigned internal investigation revealed:</p> <p>- "Internal investigation of allegations made by [client #1].</p> <p>- "On 2-05-19 [Executive Director] received a call from [County CPS] worker [CPS worker] who stated that she would be going to the [facility] facility that afternoon to interview the consumers because a call had come into CPS stating that [client #1] reported that she was being beaten on by two other consumers and the group home staff stands by and does nothing about it. [Executive Director] spoke with [CPS worker] about the incident over the weekend on 02/03/19 which involved separate physical altercation between [client #1] and two other consumers in the home which had been documented by completing the incident reports and per staff report the staff on duty Residential Counselor [Staff #1] and house manager [facility manager] did intervene. It should also be noted that [provider] perceives that the call to CPS was made by [elementary school] staff and there has been poor communication between the school and [provider]. The school seems to think the current placement is not the best for [client #1] since [provider] advocates for [client #1] to remain in school a full day while the school sends her home 3 out of five days per week for minor issues without suspended [client # 1] It has been</p>	V 296	<p>please see attached</p> 	


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V 296	<p>Continued From page 11</p> <p>expressed by [provider] that this hinders [client #1] from receiving any educational instruction and that a behavioral plan should be created to prevent these occurrences. Through internal investigation, incident reports and interviews it was determined that [client #1] was the instigator form the physical altercation and that staff acted accordingly in each instance to prevent any physical harm to [client #1] Although [client #1] was identified as provoking the incidents it is [provider] policy to not allow any consumer to do physical harm to others or themselves and that staff intervened to prevents this from occurring up to using EBPI (Evidence Based Protective Interventions) approved restraints or therapeutic hold. Therefore, [provider] is not substantiating the aforementioned allegation."</p> <p>Review on 2-27-19 of staff #2's schedule and time sheet revealed: -Staff #2 was scheduled to work on 2-3-19 from 3-11 PM. -Pay sheet indicted she was paid for 8 hours on 2-3-19.</p> <p>Review on 2-25-19 of client #1's record revealed: -Admitted 12-31-18. -10 years old. -Diagnoses of Post Traumatic Stress Disorder (PTSD), Attention Deficit/Hyperactivity Disorder (AD/HD), Oppositional Defiance Disorder, Unspecified Trauma Stressor Related Disorder. -Admission Assessment dated 12-31-18 ;" been in several foster placements and disrupted due to unmanageable behavior...goals of decreasing verbal and physical aggression and property damage...requires vigilant adult supervision."</p>	V 296	<p>please see attached</p> 


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NAME OF PROVIDER OR SUPPLIER TURN AROUND	STREET ADDRESS, CITY, STATE, ZIP CODE 9709 BATTEN COURT MINT HILL, NC 28227
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(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 296	<p>Continued From page 12</p> <p>-Comprehensive clinical assessment addendum dated 7-25-18: displayed homicidal threats, fighting with peers...impulsivity, property damage, lying, lack of focus, poor interactions with other foster children..taunting, teasing others, name calling."</p> <p>-Clinical intake dated 1-29-18: "continues to place dolls in sexual positions, point at genitalia and giggle, sleeping in the nude, and masturbating by rubbing against furniture or self-stimulation...will stop at nothing to create havoc...requires constant supervision in the home due to lack of concern for safety and and impulsive behaviors."</p> <p>-Person centered plan dated 11-14-18: "communicated threats to peers...goals include; control agitated behavior and appropriately express anger, will decrease sexualized behavior as evidenced by interacting in a non-sexual manner maintain appropriate boundaries (staff have not observed sexualized behavior)...will work to maintain composure when things do not go her way..."</p> <p>-Crisis plan includes: give clear, concise instructions, encourage, remind her of her coping skills has helped.</p> <p>Review on 2-25-19 of client #2's record revealed:</p> <p>-Admitted 12-19-18. -13 years old. -Diagnoses of PTSD, Learning Disability in Math, Learning Disability in Reading, Major Depressive Disorder Recurrent with Psychotic Features, Generalized Anxiety Disorder.</p> <p>-Admission assessment dated 12-19-18: discharged from a psychiatric residential treatment facility, history of self injurious behavior, victim of neglect by her mother.</p> <p>-Comprehensive Clinical Assessment dated</p>	V 296	<p>please see attached</p> 	


Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/04/2019
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V 296	Continued From page 13 11-27-18: "refuses to follow directions...conform to structure...difficult time interacting with peers...multiple incidents of Suicide Ideation and self harm...sexually abused by family member...Native American culture very important to her...two incidents of physical aggression...hospitalized 5-2018 and 10-2018 due to suicidal statements and significant cuts and burns on arms...recently found large knife under bed...punched herself in the face...been in multiple placements." -Person Centered Plan dated 10-17-18: goals include; demonstrate improvement in PTSD as evidenced by elimination of angry outbursts, increased optimism, expression of emotions and elimination of nightmares...will learn one appropriate coping skill as evidenced by decreasing verbal aggression. Crisis plan; speak calmly, play music. Review on 2-25-19 of client #3's record revealed: -Admitted 11-13-18. -15 years old. -Diagnoses include Unspecified Disruptive Impulse Control, Conduct Disorder, Unspecified Trauma and Stressor Reactive Disorder, Moderate Cannabis use. -Admission assessment dated 11-13-18; disrupted foster placement due to elopement, not abiding by the rules of the home or probation. -Diagnostic assessment dated 3-27-18: "ran 3 times in level II foster care, she will use substances when gone...recommend level III." -Person Centered Plan last updated 8-24-18; goals include resolve issues with department of social services placement, elopement and substance abuse, will develop two coping skills for stress, will work toward improving school behavior, will improve personal hygiene.	V 296	<i>please see attached</i> 	


Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/04/2019
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V 296	<p>Continued From page 14</p> <p>Review on 2-25-19 of staff #1's personnel record revealed: -Hire date of 9-2-18. -Training's include; EBPI base 1-23-19, reducing risks 9-8-18, behavior management, aggressive behavior 9-8-18</p> <p>Review on 2-25-19 of staff #2's record revealed: -Hire date of 1-20-19. -Trainings include EBPI 1-23-19, behavior management, unsafe behavior, and client rights 1-20-19.</p> <p>Review on 2-25-19 of staff #3's record revealed: -Hire date of 6-15-15. -Trainings include EBPI 1-23-19, Common disorders, client rights, and specific population 12-30-15.</p> <p>Review on 2-25-19 of the facility managers record revealed: -Hire date of 8-22-12. -trainings include EBPI 1-30-19, common disorders, unsafe behaviors, client rights, specific population training 8-16-12.</p> <p>Interview on 2-20-19 with client #1 revealed: -She got into an altercation with clients #2 and #3. -"They started hitting on me." -"[Staff #1] was there, she tried to break it up, but couldn't." -"[Staff #1] was trying to get them off, she was already right there." -Staff #1 was the only staff there. -When asked if staff usually work by themselves: "Sometimes [facility manager] works by herself, but she is the manager." -"They beat me up one other time too." -"The other time, two staff were there."</p>	V 296	<p><i>please see attached</i></p> 	


Division of Health Service Regulation

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V 296	Continued From page 15 -[Client #2] is a liar and when you leave she will cut herself." -"I told her if she kills herself, she will go to h*** and I will laugh." -Client #1 stated she didn't want that to happen because it would make a mess in the house. Interview on 2-26-19 with client #2 revealed: -She did remember the incident on 2-3-19. -"[Client #1] was saying rude things about her (staff #1)'s kids." -"I hit her (client #1), [client #3] kicked her, I punched her in the face." -"I don't think there was another staff there." -"Mostly females work by themselves." -"Sometimes [Staff #1] works by herself." -She doesn't remember the facility manager coming over that day. Interview on 2-20-19 and 2-26-19 with client #3 revealed: -On 2-20-19 stated she couldn't remember if one or two staff were present during the incident. -Did state that staff would work by themselves on the weekends. -The incident on 2-3-19 client #2 accidentally shut the car door in client #1's face, so client #1 deliberately shut the house door in client #2's face. -Client #2 threw water on Client #1. -"I remember, I was instigating it." -"I think [staff #2] and [staff#1], I'm pretty sure, I know [staff #1] was there." -Staff #1 told her that she couldn't hit client #1 back, and she didn't think that was reasonable. -"They were fighting in the bathroom, [staff #1] and [staff #2] was there. I'm sure because [staff #2] don't never do anything, all she does is eat rice all day."	V 296	please see attached 	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/04/2019
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V 296	<p>Continued From page 16</p> <ul style="list-style-type: none"> -She did not remember the facility manager being there. -"[Staff #5] normally works by herself." <p>Interview on 2-26-19 and 2-20-19 with client #4 revealed:</p> <ul style="list-style-type: none"> -She couldn't remember what staff was there with staff #1 on 2-3-19. -She did remember a fight between client #1 and #2. -Staff does work by themselves sometimes on the weekends, but not during the week. -Staff #1 has worked by herself before. -She just likes to stay out of things. -"I don't remember who was there, all I remember is [client #1] slapping [client #2]." <p>Interview on 2-25-19 with staff #1 revealed:</p> <ul style="list-style-type: none"> -Staff #2 usually works with her. -She normally works second shift but will sometimes work a double on the weekends. -"I like the kids, I have 5 of my own." -She was there for the incident on 2-3-19. -"That's the only one that all three were involved in." -"[Staff #2] had [client #1] and [client #2], I had [client #3] and [client #4]." -Client #3 goes home for the weekends. -"[Client #1] knows [client #3] and [client #2] don't get along." -Client #3 came back from her home visit and she and client #1 started arguing. -"[Client #1] and [Client #2] started arguing. [Client #1] said 'it's your fault your mom's dead.'" -"[Staff #2] was trying to get the clients apart." -"[Client #2] threw water on [client #1], [staff #2] got [client #2] out of the room. I'm trying to control [client #1]. [Client #1] kicked me. [Client #3] grabbed her. [Client #1] did have a scratch. I calmed the older one (client #3) down. I got the 	V 296	<p><i>please see attached</i></p> 	

Division of Health Service Regulation

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V 296	<p>Continued From page 17</p> <p>other (client #1) in her room and they went to sleep." -"I told her (client #1) that she can't be provoking the other girls." -Staff #1 said that she didn't work by herself, unless it was just two girls or a holiday, she would work by herself then. She thinks she worked Thanksgiving by herself.</p> <p>Interview on 2-25-19 with staff #2 revealed: -She had only worked there since January 2019. -She had only been there for on physical altercation and that had been the previous week with staff #3. -Staff #3 separated the clients and they calmed down. -That was the only time she had been there when the girls got in a fight.</p> <p>Interview on 2-26-19 with staff #3 revealed: -He never works by himself; "No male ever works by himself that I know of." -He had been there for a physical altercation and staff #2 had been working with him. -He immediately separated the girls when they started to fight, no one was injured.</p> <p>Interview on 2-21-19 with staff #4 revealed: -She has worked by herself sometimes, but couldn't say when the last time was. -"When I have them by myself, the clients are sleeping."</p> <p>Interview on 2-26-19 with the facility manager revealed: -She had been the manager of the home for approximately 4 years. -Staff called her on 2-3-19 when they said</p>	V 296	<p><i>please see attached</i></p> 	
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Division of Health Service Regulation

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V 296	<p>Continued From page 18</p> <p>"[client #1] was out of hand." -"[Client #1] told [client #2] she was the reason her mother was dead." -"I left home and drove there." -"[Client #2] said they were watching TV. [Client #2] got mad and they (other clients) jumped on her to fight." -"Most of the time [client #1] is a handful, Most of the time [client #1] is the first to raise her hand." -"I told [client #3] that she couldn't hit [client #1] back." -"I got there (facility) maybe 5:30-6:00." -Facility manager said she was not there for the actual altercation but got there to help calm the girls down. -She reported that staff #1 and staff #2 were there. -She works most weekends, going from house to house. -"But they always have two staff, I just make sure everything is in place." -Staff don't work by themselves. -"If there is one consumer, or two, we have one staff."</p> <p>Interview on 2-21-19 with Department of Social Services worker (Legal guardian for client #1) -She talked to her client about the fight on 2-3-19. -They are trying to move client #1 to a higher level of care. -"It's almost like they can't stop her." (from fighting) -Client #1 is not afraid at the facility. -"What I have gotten is that everyone is afraid of her." -"[Client #1] threatened to kick a pregnant staff in the stomach."</p>	V 296	<p><i>please see attached</i></p> 	

Division of Health Service Regulation

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V 296	<p>Continued From page 19</p> <p>Interview on 2-21-19 with client #1's school nurse revealed: -Client #1 had told her that she had gotten into an altercation at her facility. -She has expressed she doesn't want to be at the facility, but hasn't mentioned problems with staff. -"She focuses on herself, not staff."</p> <p>Interview on 2-19-19 and 2-25-19 with the investigating Child Protective Services worker revealed: -She had interviewed the clients and staff on 2-5-19. -All of the clients stated that there had only been one staff there at the time of the physical altercation on 2-3-19. -Clients had told her that on Saturday there was one person from 7-3 and one person 3-11. -Staff #1 originally said she could remember who was working with her, but then said staff #2 was there, "most likely." -When she interviewed staff #2, she said that she had not been there. That she had worked that weekend, but not then, and that she works Saturdays. -The facility manager said she came to help intervene when staff called her.</p> <p>Interview on 2-20-19 with the Director of Operations revealed: -Client #1 is very violent. -Client #1 will taunt clients #2 and #3 about their mothers. Client #2's mother is recently deceased and client #3's mother is incarcerated. -They are looking for a higher level of care for client #1 because she is so violent.</p> <p>Interview on 2-27-19 with the director of operations revealed:</p>	V 296	<p>please see attached</p> 	

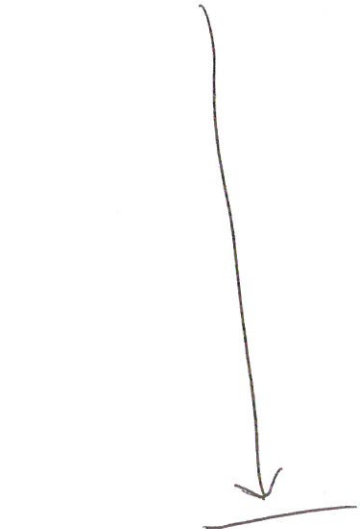
Division of Health Service Regulation

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V 296	<p>Continued From page 20</p> <ul style="list-style-type: none"> -There were two staff on duty the day of 2-3-19. -Staff #2 was hard to understand because she had a thick accent. -She might not have understood the question about was she there for the altercation. -Sometimes it was hard for staff #2 to communicate. -Staff #2 told her that the surveyor only asked her about the incident she was there for with staff #3. -Staff #2 was present and the surveyor could interview her again and she would tell me that she had been at the facility that day. -This incident happened several weeks ago. -"These girls fight all the time, staff write the incident report and move on." <p>Finding 2</p> <p>Interview on 2-21-19 with former staff #6 (FS#6) revealed:</p> <ul style="list-style-type: none"> -He would be by himself occasionally, if other staff did not come in. -"I would call the other home (sister facility), we would merge." -It would only take the sister facility 10-15 minutes to come to the facility. -They would not spend the night at the facility. <p>Interview on 2-21-19 with staff A #8 revealed:</p> <ul style="list-style-type: none"> -They have gone over the the facility when FS#6 was working by himself. -He would be there may 10-15 minutes before the sister facility A staff would get there. -"That would put 5 girls in the home." -There would be a total of 3 staff at that time. -"We would stay and have a movie night, something like that." 	V 296	<p><i>please see attached</i></p> 	

Division of Health Service Regulation

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V 296	<p>Continued From page 21</p> <p>-The sister facility A clients never spent the night, they would go back to their own facility.</p> <p>Interview on 2-26-19 with client #2 revealed: -Former staff #6 would be by himself and he would call SFA and they would come over. -It happened more than once, but she couldn't recall how many times.</p> <p>Interview on 2-27-19 with the Director of Operations revealed: -Staff were supposed to give 24 hour notice whenever possible if they were going to be unable to work their shift. -They had several floaters that they could use to fill in when needed.</p> <p>This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a type A2 rule violation and must be corrected within 23 days.</p>	V 296	<p><i>Please see attached</i></p> 	

Turnaround MHL-060-648

Plan of Correction for Complaint Survey completed

Intake #NC00148272

DHSR - Mental Health

APR 26 2019

Lic. & Cert. Section

V293 27G .1701 Residential Tx. Child/Adol - Scope

This Rule is not met as evidenced by: Based on records review and interviews, the facility did not operate within their scope by failing to ensure continuous supervision was in place to ensure safety and de-escalate out of control behaviors and failing to ensure coordination of care affecting 2 of 2 current clients(#1,#2) and 2 of 2 former clients(FC#3,FC#4).

On March 7, 2019 Executive Director James Hunt held a monthly group supervision/training to have a refresher covering scope to include review of supervision to ensure safety, person centered plans, comprehensive crisis plans, incident reports, de-escalation techniques, and better decision making for the population served amongst other topics. Each employee will continue to have monthly supervision to revisit each of these topics individually or as a whole if the need arises. The monthly supervision will be conducted by Executive Director James Hunt and/or Clinical Director Artemus Flagg. The monitoring of this will be ongoing and will be reviewed quarterly by the Quality Assurance and Quality Improvement Committee based on reviews of incident reports, staff performance, and any reported allegations or consumer complaints.

V296 27G .1704 Residential Tx. Child/Adol - Min. Staffing
10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS

This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure that two staff were present when clients were in the facility.

As of 03/02/2019 Executive Director James Hunt has met with Director of Operations Hawa Hunt to assure that each schedule created will meet minimum staffing requirements on each shift each day. As of 03/07/2019 Executive Director James Hunt met with all employees in a monthly group supervision/staffing to discuss minimum staffing. At this monthly group supervision/staffing an Acknowledgement of Employee Agreement to cover Minimum Staff Requirements was signed by each staff member to acknowledge each staff is aware of the protocol for meeting the minimum requirements in the event of no show or call outs. Monitoring of this will be conducted quarterly at the Quality Assurance/ Quality Improvement Committee meeting with a periodic review of schedules in comparisons to timesheets.



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

ROY COOPER • Governor

MANDY COHEN, MD, MPH • Secretary

MARK PAYNE • Director, Division of Health Service Regulation

March 28, 2019

Mr. James Hunt, Executive Director
New Place, Inc.
6612 E. Harris Blvd. Ste. D
Charlotte, NC 28215

Re: Complaint Survey completed 3-4-19
Turn Around, 9709 Batten Court, Mint Hill, NC 28227
MHL # 060-648
E-mail Address: hawa1908@aol.com
#NC00148272

DHSR - Mental Health

APR 26 2019

Lic. & Cert. Section

Dear Mr. Hunt:

Thank you for the cooperation and courtesy extended during the complaint survey completed 3-4-19. The complaint was substantiated.

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

- Type A2 rule violation is cited for 10A NCAC 27G .1701 Scope (293) with a cross reference of 10NCAC 27G .1704 Minimum staffing requirements (296).

Time Frames for Compliance

- Type A2 violations and all cross referenced citations must be **corrected** within 23 days from the exit date of the survey, which is 3-27-19. Pursuant to North Carolina General Statute § 122C-24.1, failure to correct the enclosed Type A2 violation(s) by the 23rd day from the date of the survey may result in the assessment of an administrative penalty of \$500.00 (Five Hundred) against New Place, Inc. for each day the deficiency remains out of compliance.

What to include in the Plan of Correction

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603

MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718

www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

March 28, 2019
Mr. James Hunt
New Place, Inc.

- 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,



Patricia Work
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: qmemail@cardinalinnovations.org
QM@partnersbhm.org
dhhs@vayahealth.com



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

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

VIA CERTIFIED MAIL

March 28, 2019

Mr. James Hunt, Executive Director
New Place, Inc.
6612 E. Harris Blvd. Ste. D
Charlotte, North Carolina 28215

DHSR - Mental Health

APR 26 2019

Lic. & Cert. Section

Re: Type A2 Administrative Penalty
Turn Around, 9709 Batten Court, Mint Hill, NC 28227
MHL # 060-648
E-mail Address: hawa1908@aol.com

Dear Mr. Hunt,

Based on the findings of this agency from a survey completed on 3-4-19, we find that New Place, Inc. has operated Turn Around in violation of North Carolina General Statute (N.C.G.S.) § 122C, Article 2, the licensing rules for Mental Health, Developmental Disabilities, and Substance Abuse Services. After a review of the findings, this agency is taking the following action:

Administrative Penalty – Pursuant to N.C.G.S. § 122C-24.1, the Division of Health Service Regulation, Department of Health and Human Services (DHHS), is hereby assessing a Type A2 administrative penalty of \$1,000.00 against New Place, Inc. for violation of 10A NCAC 27G .1701 Scope (293). Payment of the penalty is to be made to the Division of Health Service Regulation, and mailed to the Mental Health Licensure and Certification Section, 2718 Mail Service Center, Raleigh, North Carolina 27699-2718. If the penalty is not paid within sixty (60) days of this notification, a 6% penalty plus accrued interest will be added to the initial penalty amount as per N.C.G.S. § 147-86.23. In addition, the Department has the right to initiate judicial actions to recover the amount of the administrative penalty. The facts upon which the administrative penalty is based and the statutes and rules which were violated are set out in the attached Statement of Deficiencies which are incorporated by reference as though fully set out herein.

Appeal Notice – You have the right to contest the above action by filing a petition for a contested case hearing with the Office of Administrative Hearings within thirty (30) days of mailing of this letter. *Please write the facility's Mental Health License (MHL) number at the top of your petition.* For complete instructions on the filing of petitions, please contact the Office of Administrative Hearings at (919) 431-3000. The mailing address for the Office of Administrative Hearings is as follows:

MENTAL HEALTH LICENSURE & CERTIFICATION SECTION

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603
MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718
www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

3-28-19
New Place, Inc.
James Hunt

Office of Administrative Hearings
6714 Mail Service Center
Raleigh, NC 27699-6714

North Carolina General Statute § 150B-23 provides that you must also serve a copy of the petition on all other parties, which includes the Department of Health and Human Services. The Department's representative for such actions is Ms. Lisa G. Corbett, General Counsel. This person may receive service of process by mail at the following address:

Ms. Lisa G. Corbett, General Counsel
Department of Health and Human Services
Office of Legal Affairs
Adams Building
2001 Mail Service Center
Raleigh, NC 27699-2001

If you do not file a petition within the thirty (30) day period, you lose your right to appeal and the action explained in this letter will become effective as described above. *Please note that each appealable action has a separate, distinct appeal process and the proper procedures must be completed for each appealable action*

In addition to your right to file a petition for a contested case hearing, N.C.G.S. § 150B-22 encourages the settlement of disputes through informal procedures. The Division of Health Service Regulation is available at the provider's request for discussion or consultation that might resolve this matter. To arrange for an informal meeting, you must contact DHSR at 336-861-7342. Please note that the use of informal procedures does not extend the 30 days allowed to file for a contested case hearing as explained above.

Should you have any questions regarding any aspect of this letter, please do not hesitate to contact us at the Department of Health and Human Services, Division of Health Service Regulation, Mental Health Licensure and Certification Section, 2718 Mail Service Center, Raleigh, NC 27699-2718 or call Robin Sulfridge, Western Branch Manager at 336-861-7342.

Sincerely,

Stephanie Gilliam

Stephanie Gilliam, Chief
Mental Health Licensure & Certification Section

Cc: dhsreports@dhhs.nc.gov, DMH/DD/SAS
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Peggy Eagan, Director, Mecklenburg County DSS
Pam Pridgen, Administrative Assistant