STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-159	A. BUILDING: _____ B. WING _____	C 06/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD FACILITY	2002-G SHACKLEFORD ROAD KINSTON, NC 28502

(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 June 8, 2020. The complaint was unsubstantiated (Intake #NC00164516). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents.	V 000		
V 318	13O .0102 HCPR - 24 Hour Reporting 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). This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to report an allegation of abuse to the Health Care Personnel Registry (HCPR) within 24 hours of learning about the allegation. The findings are: Review on 5/13/20 of the North Carolina Incident Response Improvement System revealed no Level III incident reports by the facility regarding former client #22 between 3/01/20 and 3/30/20.	V 318		

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Review on 6/03/20 of documentation provided by the Licensee revealed no Internal Investigations regarding allegations of abuse made by former client #22.

Review on 6/03/20 of former client #22's record revealed:
- 11 year old male admitted 2/29/20 and discharged 3/31/20.
- Diagnoses included Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder, and Post Traumatic Stress Disorder, chronic.
- "Medical Progress Note" dated 3/28/20 and signed by the Registered Nurse included "Consumer was reported to be in behaviors and urinated on floor, then he slipped in the urine and reported to staff his elbow was hurting. Writer attempted to assess, however consumer refused to have assessment completed."

Review on 5/13/20 of "Level I Incident Report" for former client #22 dated 3/28/20 revealed:
- "Type of Incidents . . . aggressive or destructive act that did not involve a report to law enforcement per policy . . . Actions taken to attend to the health and safety needs of the Consumer: Counseled Cause of Incident Threw game system peed on floor . . . "

During interview on 6/02/20 former client #22's mother stated:
- Former client #22 was not available for interview.
- She visited her son on 3/16/20 and found him "covered in bruises"; he had bruises around his wrists, on his chest and sides, and one large bruise on his upper arm.
- Prior to his discharge, former client #22 called his uncle and reported that a staff had punched

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him.
- The uncle reported he heard a staff person tell former client #22 "he couldn't talk about that and if he did he would lose his phone calls".
- Former client #22 admitted to breaking a video game controller.
- Former client #22 told her after he broke the video game controller, staff followed him into his room and punched his arm.
- She could not recall the name of the staff who allegedly punched former client #22.

Review on 5/28/20 of staff #1's personnel record revealed:
- Hire date of 11/27/17, title of Paraprofessional.
- Training in "Reporting Procedures, Consumer Rights, Abuse/Neglect/Exploitation, Person Centered Plan, Behavior Management, Personal Restraints, Staff expectations, Crisis Prevention, Therapeutic Relationships, Therapeutic interventions" dated 1/23/20.

During interview on 5/28/20 staff #1 stated:
- He was assigned to the facility from another facility on the Licensee's campus in January following an allegation of abuse by another client.
- Staff involved in the previous allegation completed training in reporting allegations of abuse.
- On 3/28/20 former client #22 was in a behavior and threw a video game controller across the room.
- After throwing the video game controller, former client #22 ran into his room and slipped on the wet floor.
- Former client #22 "said I hit him or something".
- He reported the allegation to the Residential Services Supervisor (RSS) who reported it to the nurse.

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V 318	Continued From page 3 During interview on 5/28/20 the RSS stated: - Former client #22 alleged that a staff pushed him. - "The nurse and I went in and there was a lot of urine on the floor. He refused the nurse's assessment." - "I notified the AOC (Administrator on Call) and the nurse of the allegation"; per protocol, "the staff was moved immediately". During interview on 6/03/20 the Qualified Professional/AOC #2 stated: - She was the AOC on 3/28/20; she did not receive any calls about incidents or allegations of abuse on 3/28/20. - Incidents that should be called in to the AOC included injuries requiring off-campus treatment, calls to law enforcement, elopement attempts, and allegations of abuse, neglect, or exploitation. During interview on 6/01/20 the Program Director stated the facility had not done any internal investigations of allegations of abuse, neglect, or exploitation with regard to former client #22. She was not aware of any allegations of abuse made by former client #22.	V 318		