STATEMEN	of Health Service Rec	(X1) PROVIDER/SUPPLIER/CLIA	<del></del>			PRM APPROVI
	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			TE SURVEY
			A. BUILDING:		cor	MPLETED
		MHL080-122	B. WING		ľ	
JAME OF E	PROVIDER OR SUPPLIER				0	8/04/2020
			ADDRESS, CITY, STATE			
CHANCE	S GROUP HOME		ST FISHER STREE	T		
(X4) ID	SLIMMARYS	TATEMENT OF DEFICIENCIES	URY, NC 28144			
PREFIX TAG	j (EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
∨ 000	INITIAL COMMENTS		V 00 <b>0</b>			
	2020. The complain	vas completed on August 4, t was unsubstantiated . Deficiencies were cited.				
	The facility is license category: 10A NCAC Treatment Staff Secu Adolescents.	d for the following service 2 27G .1700 Residential are for Children or				
V 132	G.S. 131E-256(G) He Allegations, & Protec	CPR-Notification, tion	V 132			
	REGISTRY  (g) Health care faciliti Department is notified health care personne unknown source, whin any act listed in subdi (which includes: a. Neglect or abuse facility or a person to as defined by G.S. 13 as defined by G.S. 13 b. Misappropriation of in a health care facility (b) of this section includere services as defined	ch appear to be related to ivision (a)(1) of this section.  of a resident in a healthcare whom home care services in E-136 or hospice services in E-201 are being provided. Of the property of a resident y, as defined in subsection auding places where home ed by G.S. 131E-136 or				
	are being provided. c. Misappropriation of healthcare facility. d. Diversion of drugs facility or to a patient of e. Fraud against a he a patient or client for v providing services). Facilities must have e	belonging to a health care				

Div

DR'S OR PROVI<u>DÉR/SUPP</u>LIER REPRESENTATIVE'S SIGNATURE

President

Division	of Health Service Reg	<u>ulation</u>			FORM APPROVED
STATEMEN	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:		i i	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL080-122	B. WING		09/04/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	FATE ZIR CODE	08/04/2020
CHANCE	S GROUP HOME	712 WE	ST FISHER STR	EET	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
	to protect residents finvestigation is in proinvestigations must be Department within five notification to the Department and failed to report all alle personnel and failed to into each allegation.  Review on 8/3/20 - 8/4 revealed: -Admitted 5/22/20; -Diagnosed with Conceptage of the personnel and failed to report allegation of abuse staff #1 was unsuccessoccurred.  Attempted review on 8 staff #1 was unsuccessoccurred.	gress. The results of all e reported to the e working days of the initial partment.  The service of the initial partment of record review, the facility gations against healthcare to complete an investigation of Client #1's record of Client #1's record of the e Department regarding a made by Client #1 against aful as no reporting  1/3/20 - 8/4/20 of the ento the allegation of abuse inst Staff #1 was was no internal	V 132		8/7/20 ation
	h Comitos Doguđetien				

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Division	of Health Service Reg	ulation			FO	RM APPROVED
STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAT	E SURVEY
	MHL080-122		A. BUILDING: _		СОМ	PLETED
			B. WING		0.5	3/04/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STAT	TE, ZIP CODE		
CHANCE	S GROUP HOME		ST FISHER STREE URY, NC 28144	ΞT		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID ID	PROMBEDIE DI ANI OF COS		<u> </u>
PRÉFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACT.ON CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 132	Continued From pag	e 2	V 132			
	Interview on 8/3/20 v -Was abused by Stat hit, and threw Client -Nobody cared that S					
		vith Staff #1 revealed:				
   	-Denied ever pushing client.	g, hitting, or throwing any				!
	Interview on 8/3/20 with the DSS Investigator revealed: -Client #1 made allegations of abuse against Staff					
	#1;	_				
,   	-Ciient #1 had a histo allegations of abuse a outbursts.	ry of making false and had serious behavioral				
	Interview on 8/3/20 at Director/Licensee rev -No evidence of Clien					
	#1;	•				
		completed regarding the ade by Client #1 against				
		al investigation completed on of abuse made by Client				
İ		tions of abuse are reported e future.				
V 367	27G .0604 Incident Re	eporting Requirements	V 367			
	level II incidents, exce	REMENTS FOR				
i i		pviders premises or level III				

Division	of Health Service Reg	ulation				RM APPROVED
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION		TE SURVEY MPLETED
		MHL080-122	B. WING		08/04/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET	IDDRESS, CITY, STATE	ZIP CODE		<u>-:</u>
CHANCE	S GROUP HOME		ST FISHER STREE			
			JRY, NC 28144	•		
(X4) ID PREFIX	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORE	ON SHOULD BE COMPL HE APPROPRIATE DATE	
TAG	REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)		
V 367	Continued From pag	e 3	V 367			
	incidents and level II	deaths involving the clients				1
	to whom the provider	rendered any service within				
	ighter 90 days prior to the in	ncident to the LME				
	responsible for the ca	atchment area where				
	services are provided	within 72 hours of				ļ
	becoming aware of the	ne incident. The report shall				
	be submitted on a for	m provided by the	1			ĺ
	in person, foodmile o	t may be submitted via mail,				į .
	means. The report of	r encrypted electronic hall include the following				
l	information:	mail include the following				
		ovider contact and				
ļ	identification informat	ion;				
		fication information;				
	(3) type of incid	•				
	(4) description					
		e effort to determine the				1
	cause of the incident; (6) other individ		1			
į	or responding.	luals or authorities notified				j
		providers shall explain any				1
ļ	missing or incomplete	information. The provider				
	shall submit an update	ed report to all required				
į		e end of the next business				]
}	day whenever:					
		has reason to believe that				
	information provided in		1			
	(2) the provider	or otherwise unreliable; or obtains information				
		nt form that was previously				
	unavailable.	nicioni triat was previously				1
		providers shall submit,				
	upon request by the Li	ME, other information				, 1
	obtained regarding the	incident, including:				
		ords including confidential				
i	information;					
		her authorities; and				
i		s response to the incident.				
	(u) Category A and B	providers shall send a copy				
	4.0.1.5.1.					

SATISTANCY OF DEPRETORS    MINISTRATE   MINI	Division	of Health Service Reg	ulation				ED: 08/05/2020 RM APPROVED
MHL080-122  NAME OF PROVIDER OR SUPPLIER  CHANCES GROUP HOME  TIZ WEST FISHER STREET SALIBBURY, NC. 28144  PREFIX  SUMMARY STATEMENT OF DEFICIPOISES  IRACH DEFICIENCY MUST BE RECEDED BY THILL  REQULATORY OR ISC IDENTIFYING INFORMATION)  TAG  Continued From page 4  of all level III incident reports to the Division of Montal Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming owere of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming owere of the incident. Category A provider shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming ower of the incident. In cases of client death within seven days of use of sectusion or restraint, the provider shall report the death immediately, as required by 10 A NCAC 2EC.  JOBON and 10 A NCAC 2TC. 1014(c)(16).  (e) Category A and B providers shall send a report quarterly in 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:  (1) medication errors that do not meet the definition of a level II or level III incident;  (2) restrictive interventions that do not meet the definition of a level II or level III incident;  (3) searches of a client;  (5) the total number of level III ancident;  (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 (u) and (d) of this ROLe and SUpparagraphs (1)	STATEMEN	A DO COLATO A SERVICIO DE LA COLO DEL COLO DE LA COLO D				(X3) DAT	E SURVEY
CHANCES GROUP HOME  712 WEST FISHER STREET  SALISBURY, NC 23144  SALISBURY, NC 23144  PRODIER'S ALM OF CORRECTION  SALISBURY, NC 23144  PRODIER'S ALM OF CORRECTION  FEGULATORY OR ISC IDENTIFYING INFORMATION)  PREFIX TAG  Continued From page 4  of all level III incident reports to the Division of Montal Health, Developmental Disabilities and Substance Abuse Services within 72 hours of Decoming aware of the incident. Category A providers shall seed a copy of all level III incident Service Regulation within 72 hours of Decoming aware of the incident. In cases of client death within seven days of use of sectusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C  J300 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. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:  (1) medication errors that do not meet the definition of a level II or level III Incident;  (2) restrictive interventions that do not meet the definition of a level II or level III Incident;  (3) searches of a client or his living area;  (4) seizures of client property or property in the possession of a client;  (5) the total number of level III and level III incident;  (6) a statement incidents whenever no no not dents 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)			MHL080-122			_	
CHANCES GROUP HOME   SUMMARY STATEMENT OF DEFICIENCES     NATIO   PREFIX   SUMMARY STATEMENT OF DEFICIENCES   PROJECT READ DEFICIENCY MUST BE PRECEDED BY FILL     PREFIX   PROJECT OF ALSO IDENTIFYING INFORMATION)   DEFICE     TAG	NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS CITY STATE	ZIP CODE		5/04/2020
SALISBURY, NC 28144   SUMMARY STATEMENT OF DEPICENCIES   SPECIAL PROPERTY   SUMMARY STATEMENT OF DEPICENCIES   PROPERTY	CHANCE:	S GROUP HOME					
TAG PREFIX TAG PREFICIENCY WUST BE PAREDED BY FULL PROPERLY TAG CROSS-REPERRED TO THE APPROPRIATE CONFIDENTIFYING INFORMATION)  V 387  Continued From page 4  of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of Decoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of Decoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall send a proportion of the provider shall send a copy of all level III incidents involving a client death within seven days of use of seclusion or restraint, the provider 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:  (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his iving area; (4) seizures of client property or property in the possession of a clent; (5) the total number of level III and level III incidents that occurred; and (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 (1)			SALISBI		•		
of all level III incident reports to the Division of Mentai Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming eware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of sectusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 2EC 0.300 and 10A NCAC 2EC 1014(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:  (1) medication errors that do not meet the definition of a level II or level III incident;  (2) restrictive interventions that do not meet the definition of a level II or level III incident;  (3) searches of a client or his living area;  (4) seizures of client property or property in the possession of a client;  (5) the total number of level II and level III incidents that occurred; and  (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)	PREFIX	{EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP.	EACH CORRECTIVE ACTION SHOULD BE COSS-REFERENCED TO THE APPROPRIATE	
of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming eware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of 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 28C .0.300 and 10A NCAC 27E .0.104(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:  (1) medication errors that do not meet the definition of a level II or level III incident;  (2) restrictive interventions that do not meet the definition of a level II or level III incident;  (3) searches of a client or his living area:  (4) seizures of client property or property in the possession of a client;  (5) the total number of level II and level III incidents that occurred; and  (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)	V 367	Continued From page	e 4	V 367			
		of all level fll incident Mental Health, Develous Substance Abuse Serbecoming aware of the providers shall send a incidents involving a commendate of the client death within sever restraint, the provide immediately, as required to the Category A and Breport quarterly to the catchment area where The report shall be subly the Secretary via elinclude summary inform (1) medication eleginition of a level flow (2) restrictive interest the definition of a level flow (3) searches of a client (4) seizures of a client (5) the total number of the possession of a client (6) a statement incidents that occurred (6) a statement incidents have occurred (7) and (8) of this Rule	reports to the Division of opmental Disabilities and rvices within 72 hours of the incident. Category A category of all level III client death to the Division of ation within 72 hours of the incident. In cases of the days of use of seclusion and the second of the death red by 10A NCAC 26C 27E .0104(e)(18).  The providers shall send a LME responsible for the deservices are provided. In the death red by 10A ncac and shall responsible for the deservices are provided. In the death red by 10A ncac and shall responsible for the deservices are provided. In the death responsible for the deservices are provided. In the death responsible for the deservices are provided. It is a client on a follows:  The responsible for the death responsible for the decironic means and shall report that do not meet the or level III incident; and level III incident; and report of level II and level III is and redicating that there have idents whenever no deduring the quarter that as set forth in Paragraphs and Subparagraphs (1)	V 367			

<u>Division</u>	of Health Service Reg	ulation			FORM	M APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE ( COMPL	
		MHL080-122	B. WING		08/04/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE		7472020
CHANCES	GROUP HOME		ST FISHER STRE URY, NC 28144	ET		İ
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 367	Continued From pag	e 5	V 367			·
	failed to report all lev (Local Management I catchment area wher within 72 hours of be incident.  Review on 8/3/20 - 8 revealed: -Admitted 5/22/20; -Diagnosed with Con-14 years old.  Attempted review on facility's Level III incide allegation of abuse m Staff #1 was unsucce was completed.  Interview on 8/3/20 w-Was abused by Staff hit, and threw Client #-Nobody cared that S  Interview on 8/3/20 w-Denied ever pushing client.  Interview on 8/3/20 wirevealed: -Client #1 made alleg: #1; -Client #1 had a historial	and record review, the facility et III incidents to the LME Entity) responsible for the reservices are provided coming aware of the M4/20 of Client #1's record duct Disorder and ADHD;  8/3/20 - 8/4/20 of the dent report regarding the restriction as no incident report restriction in Client #1 against restrictions as no incident report in the Client #1 revealed:  #1 when Staff #1 pushed,  #1;  #1 abused him.  #1 this Staff #1 revealed:  #4, hitting, or throwing any  #1 the DSS Investigator readings of abuse against Staff		We will in the report all all of abuse on in the Inis we still ass info 40 t care Resist	future legation 5 & neglect system. b put tealth	8/8/20
	Interview on 8/3/20 ar	nd 8/4/20 with the		<del></del>	}	

Division	of Health Service Regi	ulation			FO	RM APPROVED	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION				
	O. COMMECTION	IDENTIFICATION NUMBER:				E SURVEY IPLETED	
		MHL080-122	B. WING		١ ,	8/04/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIR CODE		6/04/2020	
CHANCES	S GROUP HOME		ST FISHER STREE				
O I A I O L	S GROUP HOWE		URY, NC 28144				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION		
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETE	
			TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	ROPRIATE	DATE	
V 367	Continued From page	e 6	V 367				
	Director/Licensee rev		V 367			i	
'	-No evidence of Clien	realed: nt #1 being abused by Staff				ļ	
ļ	#";	K #1 being abased by Stall					
	-There was no incider	nt report completed	ļ				
	regarding the allegation	on of abuse made by Client					
	#1 against Staff #1; -Will ensure all allega	tions of abuse are reported					
	to the LME using North	th Carolina Incident					
	Response Improveme	ent System (NC IRIS) in the					
	future.						
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NewPath Youth Services Inc.					
Fax Cover Sheet					
To: NCDHSR					
FROM: <u>NEWPATH YOUTH SERVICES INC.</u>					
FAX# 919-715-8078					
Notes:					

**Confidential Fax**