STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-150	A. BUILDING: _____ B. WING _____	09/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE HOUSE	3775 OLD LOWERY ROAD SHANNON, NC 28386

(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 September 29, 2020. The complaint was unsubstantiated (intake #NC00169314). Deficiencies were cited. This facility is licensed for the following category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.	V 000		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the	V 132		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-150	A. BUILDING: _____ B. WING _____	09/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE HOUSE	3775 OLD LOWERY ROAD SHANNON, NC 28386

(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 132	Continued From page 1 investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to report an allegation of abuse to the Health Care Personnel Registry (HCPR). The findings are: Review on 09/25/20 of facility records for former client (FC) #4 revealed no notification of the HCPR of an allegation of abuse against staff #4 nor a 5 day investigation submitted per rule. Review on 09/17/20 of FC #4's record revealed: - 12 year old male. - Admission date of 08/13/20. - Diagnoses of Oppositional Defiant Disorder, Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder and Post Traumatic Stress Disorder. - Date of discharge 09/06/20. Review on 09/17/20 of an undated "Internal Investigation for Hope House September 11 2020" signed by the Licensee revealed: - "On Friday, Sept. 11 2020. [Local] county dept.	V 132		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-150	A. BUILDING: _____ B. WING _____	09/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE HOUSE	3775 OLD LOWERY ROAD SHANNON, NC 28386

(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 132	Continued From page 2 (department) of Social Services came to Hope House and informed me ([Licensee Name]) that a complaint had been filed against a staff member ([Staff #4]). The complaint was that during a restraint on Sept. 04 2020, [Staff #4] call member ([FC #4]) a b****. The restraint was to prevent member from doing harm to himself. member has a history of self-injurious behaviors as well as sexualized behaviors. Member was admitted to Hope House on 8-12-20 from [Mental health Facility] PRTF. On 08-25-20, while at therapy, member became aggressive and combative. He stated the therapist was looking at him creepy. Member was so out of control that he was transported to [Local] hospital by EMS (Emergency Medical Services). Member was assessed and transferred to [Another Mental Health Facility]. He returned to Hope House on the evening of 09-03-20. On the morning of 09-04-20, member was out of control again. When staff contacted me, I could hear the member screaming that he wanted to kill himself. Member had a virtual appointment with Dr. [Name] at [Local] clinic that evening. member continued to express suicidal ideations to the doctor along with a plan. member was ivc'ed (involuntary committed) to [another Local] Hospital. I was at the facility for most of the day and member did not at any time express to anyone that Mr. [Staff #4] had said anything untherapeutic to him. The day shift staff member ([Staff #6]) stated he didn't hear anything wrong said either. Mr. [Staff #6] monitored [FC #4] the entire day until he left the facility by EMS. [Department of Social Services Representative] (RCDSS ([local] County Department of Social Services)) interviewed the three remaining members and staff. As part of my investigation, I had all witnesses to write statements,which I have attached. Based on my investigation, I have	V 132		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-150	A. BUILDING: _____ B. WING _____	09/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE HOUSE	3775 OLD LOWERY ROAD SHANNON, NC 28386

(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 132	Continued From page 3 not substantiated abuse or neglect." Interview on 09/25/20 the Licensee stated: - She had completed an investigation into FC #4's allegation of abuse. - She had not completed the notification of HCPR. - She had completed an internal investigation but had not sent the report into HCPR. - She understood the HCPR needed to be notified of any allegation of abuse and an internal investigation within 5 business days.	V 132		
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 allegations of abuse to the Health Care Personnel Registry (HCPR) within 24 hours of learning about the allegation. The	V 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-150	A. BUILDING: _____ B. WING _____	09/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE HOUSE	3775 OLD LOWERY ROAD SHANNON, NC 28386

(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 318	Continued From page 4 findings are: See Tag V132 for specifics. Review on 09/25/20 of the North Carolina Incident Response Improvement System (IRIS) website from September 1, 2020 thru September 25, 2020 revealed: - No documented evidence the allegation of abuse against staff #4 was submitted to the HCPR within 24 hours as required. Interview on 09/25/20 the Licensee stated: - She was notified of former (FC) #4's allegation on 09/11/20. - She had completed an internal investigation regarding FC #4's allegation. - She understood an allegation of abuse was required to the HCPR within 24 hours of learning about the allegation.	V 318		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-150	A. BUILDING: _____ B. WING _____	09/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE HOUSE	3775 OLD LOWERY ROAD SHANNON, NC 28386

(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 367	Continued From page 5 means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming 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 becoming aware of the incident. In cases of client death within seven days of use of seclusion	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-150	A. BUILDING: _____ B. WING _____	09/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE HOUSE	3775 OLD LOWERY ROAD SHANNON, NC 28386

(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 367	Continued From page 6 or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 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 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) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure a critical incident report was submitted to the Local Management Entity (LME) within 72 hours as required. The findings are. See Tag V132 for specifics.	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-150	A. BUILDING: _____ B. WING _____	09/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE HOUSE	3775 OLD LOWERY ROAD SHANNON, NC 28386

(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 367	Continued From page 7 Review on 09/25/20 of the North Carolina Incident Response Improvement System (IRIS) for FC #4 revealed no report of an allegation of abuse against staff #4 dated 09/11/20 had been submitted to the LME/MCO within 72 hours as required. Interview on 09/25/20 the Licensee stated: - She had been notified about the allegation from a local Department of Social Services representative on 09/11/20. - She had not completed an IRIS report for the allegation from former client #4. - She understood an IRIS report was required for allegations of abuse within 72 hours.	V 367		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-150	A. BUILDING: _____ B. WING _____	09/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE HOUSE	3775 OLD LOWERY ROAD SHANNON, NC 28386

(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 537	Continued From page 8	V 537		

demonstrated.
(c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions.
(d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(e) Formal refresher training must be completed by each service provider periodically (minimum annually).
(f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.
(g) Acceptable training programs shall include, but are not limited to, presentation of:
(1) refresher information on alternatives to the use of restrictive interventions;
(2) guidelines on when to intervene (understanding imminent danger to self and others);
(3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention);
(4) strategies for the safe implementation of restrictive interventions;
(5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention;
(6) prohibited procedures;
(7) debriefing strategies, including their

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-150	A. BUILDING: _____ B. WING _____	09/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE HOUSE	3775 OLD LOWERY ROAD SHANNON, NC 28386

(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 537	Continued From page 9 importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner;	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-150	A. BUILDING: _____ B. WING _____	09/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE HOUSE	3775 OLD LOWERY ROAD SHANNON, NC 28386

(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 537	Continued From page 10 (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-150	A. BUILDING: _____ B. WING _____	09/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE HOUSE	3775 OLD LOWERY ROAD SHANNON, NC 28386

(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 537	Continued From page 11 preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure one of two audited staff (#5) demonstrated competence in the proper use of restraints. The findings are: Review on 09/17/20 of former client (FC) #2's record revealed: - 16 year old male. - Admission date of 11/18/19. - Diagnoses of Unspecified Depressive Disorder, Oppositional Defiant Disorder and Attention Deficit Hyperactivity Disorder. - Discharge date of 09/15/20. Review on 09/29/20 of staff #5's personnel record revealed: - Date of hire: 09/10/19. - National Crisis Intervention (NCI) Plus 08/22/20. Review on 09/17/20 of a North Carolina Incident Response Improvement System (IRIS) report for FC #2 revealed: - Date of incident: 09/10/20. - Time of Incident: 8:30am. - Provider Comments: "On 9/10/20, Staff (#5) was supervising member (FC #2) as he completed his remote learning. Staff instructed member to change his seating position to another area, so that staff could monitor his computer usage more closely; due to his recent behaviors. Member refused to comply with staff directives at this time, citing "you going to try and go behind the manager ' s back and change things". At this time	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-150	A. BUILDING: _____ B. WING _____	09/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE HOUSE	3775 OLD LOWERY ROAD SHANNON, NC 28386

(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 537	Continued From page 12	V 537		

staff informed the member that the decision to change his seating arrangement had been made during the staff meeting. Staff directed member to take a time out in his room as he was disrupting the learning of his peers. Member continued to be disruptive but complied and went to his room. Staff continued monitoring member as he remained in his room, and he began making verbal threats toward staff. Member then demanded to be allowed to return to the dining room for remote learning. Staff informed member that due to his aggressive and non-compliant behaviors, he would need to demonstrate compliance and a calm demeanor before he would be permitted on the floor. At this time, member became escalated and began telling staff that he "wasn ' t going to do nothing" as he began balling his fists and posturing towards staff. Staff verbally redirected member to utilize his coping skills and calm down. Member attempted to shove staff and staff directed client to stop or he would have to be restrained due to him being aggressive. At this time, member rushed at staff and staff placed member into a standing therapeutic hold that lasted 14 minutes. While staff was in the hold, he continued to be combative. Member was attempting to swing and fight with staff while staff was attempting to keep him subdued, which resulted in staff ' s facemask being ripped from his face. Staff was able to hold member to keep him from assaulting staff with his fists, but member was biting and pinching staff still. At this time, staff released member and was able to get free from member ' s grasp as well. Member then began posturing toward staff and attempted to assault staff once again. Again, due to the combative nature of client, staff was then able to administer the therapeutic hold. While place was being placed in a second hold staff and member had fallen to the ground entangled; with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-150	A. BUILDING: _____ B. WING _____	09/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE HOUSE	3775 OLD LOWERY ROAD SHANNON, NC 28386

(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 537	Continued From page 13	V 537		

member having a hold of staff ' s neck and head while staff had a secure hold on member as well. Staff maintained this positioning for 12 minutes due to member ' s continued aggressiveness and combative nature. During the hold, member continued to bite and pinch staff. Staff maintained this positioning until member began to show signs of de-escalation. Once member was de-escalated, staff released member and the member processed with secondary staff (#2) about the incident."
- "Describe the cause of this incident, (the details of what led to this incident). Due to client previously going on inappropriate sites, he was informed that he would have to be monitored while on computer during school time. Client became angry because he did not want to be monitored."
- "Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. In the future if changes are made to supervision of clients during school time, the QP or the manager will inform the client of what is to occur prior to the time it is to start."

Review on 09/17/20 of a facility restrictive intervention report for FC #2 revealed:
- Date of incident: 09/10/20.
- Time of incident: 8:30am.
- Type of interventions - 2 standing for duration of 26 minutes.
- FC #2 was posturing and verbally aggressive with staff before become physically aggressive.
- "Describe debriefing with individual and/or guardian: Staff counseled with member to determine the cause of the incident and what methods may work best in the future to avoid therapeutic restraints. member stated that he "did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-150	A. BUILDING: _____ B. WING _____	09/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE HOUSE	3775 OLD LOWERY ROAD SHANNON, NC 28386

(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 537	Continued From page 14	V 537		

nothing" and was being calm, quiet and compliant. Member minimized his role in the incident and showed minimal processing. member was able to admit wrong doing in some of his re-telling of his story, but there were obvious lapses in time and the accuracy of his account is questionable."
- "Describe debriefing with staff:...The incident was discussed with staff (#5). Staff was coached and role modeled on how to interact with clients while in an escalated state. Staff will receive further training and coaching at the bi-weekly all-staff meetings about client/staff interactions, in an effort to reduce future restrictive interventions."

Interview on 09/18/20 FC #2 stated:
- He had been in an altercation with staff #5.
- Staff #5 slammed him to the ground. He did not have to seek medical treatment.
- He did speak with other staff about the incident and took some photos. He had some bruises.
- No other clients saw him get slammed.
- Staff #2 told staff #5 to get off of me.

Interview on 09/15/20 staff #5 stated:
- He had not seen any clients mistreated or harmed.
- Staff may put clients in standing therapeutic holds for no more than 15 minutes at a time.
- If a client drops their weight or goes to the floor staff should let them go.

Interview on 09/21/20 staff #2 stated:
- He was at the facility when staff #5 put FC #2 in a therapeutic hold.
- He saw the hold was on the floor. He was not taught to do a hold on the
- floor.
- He could tell by staff #5's voice he was getting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-150	A. BUILDING: _____ B. WING _____	09/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE HOUSE	3775 OLD LOWERY ROAD SHANNON, NC 28386

(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 537	Continued From page 15 upset. 2 staff are at the facility to trade out if needed. Interview on 09/24/20 the Therapeutic Restraint Instructor stated: - The facility was taught National Crisis Interventions (NCI) Plus. - He did not teach restraints on the floor. - Staff would normally release a hold if they were losing their balance. Interview on 09/25/20 the Licensee stated: - FC #2 wanted to get out of the facility. - She understood NCI Plus did not teach restraints on the floor. - She understood potential for injuries with falls during physical restraints. - She would follow up to ensure staff demonstrated proper technique with restraints.	V 537		