| STATEMENT OF DEFICIENCIES (X<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |  |                                   | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|--|---|--|-----------------------------------|-------------------------------|--|
|  |  |  | A. BOLDING.                             |  |                                   |                               |  |
|  |  | MHL060-757   | B. WING                                 |  | 02                                | 2/23/2021                     |  |
| NAME OF PF   | ROVIDER OR SUPPLIER  | STREET A   | ADDRESS, CITY, STATE                    | , ZIP CODE   |                                   |                               |  |
| BRITE HO   | RIZON  |  | /INDY WOOD COUF<br>OTTE, NC 28273       | RT   |                                   |                               |  |
| (X4) ID<br>PREFIX<br>TAG                               | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE       |  |
| V 000  | INITIAL COMMENTS   | 3  | V 000                                   |  |                                   |                               |  |
|  | The complaint was u<br>#NC174570). Deficie<br>This facility is license   | vas completed on 2/23/21.<br>nsubstantiated(Intake<br>ncies were cited.<br>ed for the following service<br>27G .1700 Residential |   |  |                                   |                               |  |
|  | Treatment Staff Secu<br>Adolescents.   |  |   |  |                                   |                               |  |
| V 110  | 27G .0204 Training/S<br>Paraprofessionals  | Supervision  | V 110                                   |  |                                   |                               |  |
|  | <ul><li>SUPERVISION OF F</li><li>(a) There shall be no paraprofessionals.</li><li>(b) Paraprofessional associate profession</li></ul>  |  |   |  |                                   |                               |  |
|  | Subchapter.<br>(c) Paraprofessional<br>knowledge, skills and<br>population served.   | abilities required by the  |   |  |                                   |                               |  |
|  | then qualified professionals shall d   | a competency-based<br>is established by rulemaking,<br>sionals and associate<br>emonstrate competence.<br>Ill be demonstrated by |   |  |                                   |                               |  |
|  | <ul> <li>exhibiting core skills</li> <li>(1) technical knowle</li> <li>(2) cultural awarene</li> <li>(3) analytical skills;</li> </ul> | including:<br>edge;  |   |  |                                   |                               |  |
|  | <ul><li>(4) decision-making</li><li>(5) interpersonal sk</li><li>(6) communication s</li></ul>   | ills;  |   |  |                                   |                               |  |
|  | develop and impleme  | dy for each facility shall<br>ent policies and procedures<br>e individualized supervision  |   |  |                                   |                               |  |

| STATEMENT                | of Health Service Regu<br>FOF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |   |                                    | E SURVEY<br>PLETED       |
|--------------------------|--|--|---|---|------------------------------------|--------------------------|
|                          |  | MHL060-757   | B. WING                                 |   | 02                                 | 2/23/2021                |
| NAME OF PI               | ROVIDER OR SUPPLIER  | STREET A   | ADDRESS, CITY, STATE                    | , ZIP CODE  |                                    |                          |
| BRITE HO                 | RIZON  |  | /INDY WOOD COUF<br>OTTE, NC 28273       | RT  |                                    |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)                                    | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN O<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | CTION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETI<br>DATE |
| V 110                    | Continued From page  | e 1  | V 110                                   |   |                                    |                          |
|                          | plan upon hiring each  | n paraprofessional.  |   |   |                                    |                          |
|                          | interviews, the facility<br>paraprofessionals de   | view, observations and   |   |   |                                    |                          |
|                          | revealed:<br>-date of hire 7/26/19<br>Paraprofessional;<br>-documentation of co<br>following: Orientation<br>CPR(Cardiopulmonal<br>5/4/19, NCI+ (North C | mpleted trainings in the<br>7/26/19,<br>ry Resuscitation)/First Aid<br>Carolina Interventions)<br>ulations(Mental Health |   |   |                                    |                          |
|                          | from 11/1/20 to 2/22/2<br>-incident report dated<br>regarding client #1;<br>-client #1 left his roor<br>placement;<br>-client #1 made the s              | l 2/17/21 at 4:25pm  |   |   |                                    |                          |
|                          | -brick ranch style hou<br>leading to a foyer;  | 21 at 12:25pm revealed:<br>use with the front door<br>ver was a door leading to a  |   |   |                                    |                          |

STATE FORM

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |  |                                   | E SURVEY<br>IPLETED     |
|---|--|---|---|--|-----------------------------------|-------------------------|
|   |  |   | A. BUILDING.                            |  |                                   |                         |
|   |  | MHL060-757  | B. WING                                 |  | 02                                | 2/23/2021               |
| NAME OF PI  | ROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, STATE,                    | , ZIP CODE   |                                   |                         |
| BRITE HO  | RIZON  |   | /INDY WOOD COUR<br>DTTE, NC 28273       | RT   |                                   |                         |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| V 110   | Continued From pag   | e 2   | V 110                                   |  |                                   |                         |
|   | right;<br>-two bedrooms were<br>a bathroom and a be<br>the hallway;<br>-client #1's bedroom<br>left at the end of the<br>-in the den was a tab<br>-the facility phone wa<br>table;<br>-a door from the den<br>Interview on 2/22/21<br>-heard client #1 use<br>-heard client #1 use<br>-heard client #1 say I<br>-staff #1 was outside<br>-can't remember if ar<br>-client #1 stated he w<br>down;<br>-client #1 stated he w<br>down;<br>-client #1 said he tho<br>Interview on 2/23/21<br>-prank called his prio<br>-remembered the phy<br>placement;<br>-was at the facility wi<br>-client #3 and client #<br>Professional (QP) to<br>-staff #1 was outside<br>-used facility phone i<br>placement;<br>-felt it would be fun;<br>-fold prior placement<br>-it was not true. | and to a den area on the<br>on the left of the hallway and<br>droom were on the right of<br>was the last bedroom on the<br>hallway;<br>be beside the fireplace;<br>as located on a shelf of the<br>lead to the kitchen.<br>with client #2 revealed:<br>the facility phone;<br>he was getting raped;<br>on his cell phone;<br>hother staff was at the facility;<br>vanted to get the facility shut<br>ught it was funny to do it.<br>with client #1 revealed:<br>r placement;<br>one number of his prior<br>th client #2;<br>#4 went with the Qualified<br>the office;<br>acility with him and client #2;<br>talking on his own phone;<br>n den to call his prior<br>he was getting raped;<br>with staff #1 revealed:<br>; |   |  |                                   |                         |

Division of Health Service Regula STATE FORM

6899

| AND PLAN OF CORRECTION |  |  |                                   | (X2) MULTIPLE CONSTRUCTION A. BUILDING:                |                 | E SURVEY<br>PLETED |
|------------------------|--|--|-----------------------------------|--|-----------------|--------------------|
|                        |  | MHL060-757   | B. WING                           | B. WING  |                 | /23/2021           |
| NAME OF P              | ROVIDER OR SUPPLIER  | STREET A   | ADDRESS, CITY, STATE,             | ZIP CODE   |                 |                    |
| BRITE HO               | RIZON  |  | /INDY WOOD COUR<br>OTTE, NC 28273 | Т  |                 |                    |
| (X4) ID                | SUMMARY ST   | TATEMENT OF DEFICIENCIES   | ID                                | PROVIDER'S PLAN O                                      | F CORRECTION    | (X5)               |
| PREFIX<br>TAG          |  | EY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | PREFIX<br>TAG                     | (EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | THE APPROPRIATE | COMPLET            |
| V 110                  | Continued From page  | e 3  | V 110                             |  |                 |                    |
|                        | personal phone;<br>-stepped outside on f<br>-phone call was only<br>-heard the facility pho<br>-answered and a mal<br>prank calling people?<br>-realized both he and<br>facilities;<br>-gave male caller the<br>Director;<br>-discovered client #1<br>twice from the facility<br>being raped.<br>Interview on 2/22/21<br>-designated quiet tim<br>5:00pm for clients;<br>-client #1 got the faci<br>calls without permiss<br>-staff #1 was comple<br>getting dinner ready;<br>-staff #1 was at the fa<br>#2.<br>Interview on 2/22/21<br>-will provide more clin<br>-had a staff meeting of<br>proximity control.<br>Review on 2/22/21 of<br>the Director revealed<br>-staff meeting agenda<br>attached staff signatu-<br>-topics included clinic | 6-7 minutes;<br>one ringing;<br>le said "are you having fun<br>?"<br>d male caller worked at<br>e contact information for the<br>called his prior placement<br>phone and alleged he was<br>with the QP revealed:<br>he was from 4:15pm until<br>lity phone and made phone<br>ion;<br>ting medication counts and<br>acility with client #1 and client<br>with the Director revealed:<br>nical oversight for staff #1;<br>with staff to discuss<br>f documentation produced by<br>l:<br>a dated 2/18/21 with<br>ure sheet;<br>cal oversight, proximity<br>ct policy and supervision; |                                   |  |                 |                    |

6899

|                          | F OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE C                   |   | E SURVEY<br>PLETED                   |                         |
|--------------------------|--|--|-----------------------------------|---|--------------------------------------|-------------------------|
|                          |  |  | A. BUILDING:                      |   |                                      |                         |
|                          |  | MHL060-757   |                                   |   | 02                                   | 2/23/2021               |
| NAME OF P                | ROVIDER OR SUPPLIER  |  | ADDRESS, CITY, STATE              |   |                                      |                         |
| BRITE HC                 | RIZON  |  | VINDY WOOD COUF<br>OTTE, NC 28273 | XI  |                                      |                         |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  | ID<br>PREFIX<br>TAG               | PROVIDER'S PLAN C<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TC<br>DEFICIE! | CTION SHOULD BE<br>D THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| V 296                    | Continued From page  | e 4  | V 296                             |   |                                      |                         |
| V 296                    | 27G .1704 Residentia<br>Staffing   | al Tx. Child/Adol - Min.   | V 296                             |   |                                      |                         |
|                          | telephone or page. A<br>able to reach the faci<br>times.<br>(b) The minimum nur<br>required when childre<br>present and awake is<br>(1) two direct of<br>one, two, three or four<br>(2) three direct<br>for five, six, seven or<br>adolescents; and<br>(3) four direct of<br>nine, ten, eleven or tw<br>adolescents.<br>(c) The minimum nur<br>during child or adoles<br>follows:<br>(1) two direct of<br>and one shall be awa<br>children or adolescent<br>(2) two direct of<br>and both shall be awa<br>children or adolescent<br>(3) three direct<br>of which two shall be<br>asleep for nine, ten, e<br>adolescents.<br>(d) In addition to the<br>care staff set forth in<br>Rule, more direct care<br>the facility based on the | asional shall be available by<br>A direct care staff shall be<br>lity within 30 minutes at all<br>mber of direct care staff<br>en or adolescents are<br>as follows:<br>are staff shall be present for<br>ir children or adolescents;<br>care staff shall be present<br>eight children or<br>care staff shall be present for<br>welve children or<br>mber of direct care staff<br>scent sleep hours is as<br>are staff shall be present<br>ike for one through four<br>nts;<br>are staff shall be present<br>ake for five through eight |                                   |   |                                      |                         |

|                          | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                                   |  |                                   | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|--|-----------------------------------|--|-----------------------------------|-------------------------------|--|
|                          |   |  |                                   |  |                                   |                               |  |
|                          |   | MHL060-757   | B. WING                           |  | 02                                | 2/23/2021                     |  |
| NAME OF PI               | ROVIDER OR SUPPLIER   |  | DDRESS, CITY, STATE               |  |                                   |                               |  |
| BRITE HO                 | RIZON   |  | /INDY WOOD COUF<br>DTTE, NC 28273 | RT   |                                   |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG               | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE       |  |
| V 296                    | Continued From page   | e 5  | V 296                             |  |                                   |                               |  |
|                          | supervision of childre<br>are away from the fac   | I be responsible for ensuring<br>en or adolescents when they<br>cility in accordance with the<br>individual strengths and<br>the treatment plan. |                                   |  |                                   |                               |  |
|                          | interviews, the facility  | view, observations and<br>/ failed to ensure the<br>cting 4 of 4 clients (#1, #2,  |                                   |  |                                   |                               |  |
|                          | -prank called his prio<br>-remembered the pho<br>placement;<br>-was at the facility wi<br>-client #3 and client #<br>Professional (QP) to | one number of his prior<br>th client #2;<br>#4 went with the Qualified   |                                   |  |                                   |                               |  |
|                          | -heard client #1 use t<br>-staff #1 was outside   |  |                                   |  |                                   |                               |  |
|                          | Interview on 2/22/21<br>-two staff on all shifts<br>-one staff on third shi<br>-only one staff here la<br>-did not remember w             | ift sometimes;<br>ast night on third;  |                                   |  |                                   |                               |  |
|                          | Interview on 2/22/21<br>-two staff on every sh<br>alth Service Regulation   | with client #4 revealed:<br>nift;  |                                   |  |                                   |                               |  |

| TATEMEN                  | of Health Service Regu<br>FOF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING |   |                                      | E SURVEY<br>PLETED      |
|--------------------------|--|---|---|---|--------------------------------------|-------------------------|
|                          |  | MHL060-757  |   |   | 02/23/2021                           |                         |
| AME OF P                 | ROVIDER OR SUPPLIER  |   | DDRESS, CITY, STATE,                            |   | 02                                   | 2/23/2021               |
| RITE HO                  | RIZON  |   | INDY WOOD COUR<br>DTTE, NC 28273                | RT  |                                      |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                             | PROVIDER'S PLAN (<br>(EACH CORRECTIVE A<br>CROSS-REFERENCED T(<br>DEFICIE | CTION SHOULD BE<br>O THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| V 296                    | Continued From pag   | e 6   | V 296   |   |                                      |                         |
|                          | -two staff worked thir   | rd shift last night.  |   |   |                                      |                         |
|                          | -designated quiet tim<br>5:00pm for clients;<br>-client #1 got the faci<br>calls without permiss<br>-staff #1 was at the fa<br>#2;<br>-she took client #3 ar<br>office.<br>Review on 2/23/21 o<br>record revealed no a | with the QP revealed:<br>he was from 4:15pm until<br>ality phone and made phone<br>sion;<br>acility with client #1 and client<br>and client #4 to the doctor's<br>f client #3 and client #4's<br>approved 1:1 staff/client ratio<br>cumented in the treatment |   |   |                                      |                         |