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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		(X3) DATE SURVEY COMPLETED	
ANDIEAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING:		OOWII EE	-120
		MHL0601226	B. WING		03/1	8/2021
NAME OF PROVIDER OR SUPPLIER STREET ADD			RESS, CITY, STA	TE, ZIP CODE		
PEACE COTTAGE			「PETER'S LA S, NC 28105	NE, SUITE 200		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETE DATE
V 000	INITIAL COMMENTS	i	V 000			
	2021. The complaint #NC 00173789). A d	d for the following service C 27G. 1900 Psychiatric				
	Adolescents.					
V 315	27G .1902 Psych. Re	s. Tx. Facility - Staff	V 315			
	physician board-eligit psychiatry or a gener experience in the trea adolescents with mer (b) At all times, at lea members shall be pre or adolescents in eac (c) If the PRTF is hos specifically assigned responsibilities separ an acute medical unit (d) A psychiatrist sha consultation to review or adolescent admitted	I be under the direction a cole or certified in child ral psychiatrist with atment of children and chal illness.  ast two direct care staff resent with every six children ch residential unit.  Ispital based, staff shall be to this facility, with rate from those performed on to or other residential units.  all provide weekly weekly we medications with each child red to the facility.				
	This Rule is not met Based on record revie observations, the faci direct care staff were	ews, interviews, and ility failed to ensure that two				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division	of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL0601226	B. WING		03/1	8/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
PEACE COTTAGE			IT PETER'S LA VS, NC 28105	NE, SUITE 200		
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 315	Continued From page	e 1	V 315			

children or adolescents in each residential unit.

Review on 2-23-21 of Client #1's record revealed:

-diagnosed with Post Traumatic Stress Disorder,

Review on 2-23-21 of Client #2's record revealed:

Review on 2-23-21 of Client #3's record revealed:

-diagnosed with Reactive Attachment Disorder,

Intellectual Functioning, and Provisional diagnosis

-the clients and staff were leaving the cottage for

Interview on 2-22-21 with Client #1 revealed: -2 or 3 staff worked when Client #1 was

-"during the night I think 1 staff works while we

-there were 2, 3, or 4 staff working in the

Attention Deficit Hyperactivity Disorder, Generalized Anxiety Disorder, Borderline

Observation at 10:10am on 2-22-21 of the

-5 female clients were in the cottage;-3 female staff members were on duty in the

school at the time of the observation.

awakened in the morning;

-diagnosed with Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Generalized Anxiety disorder, Post Traumatic Stress Disorder, and Schizoaffective Disorder.

Chronic Anxiety, and Major Depression.

The findings are:

-admitted 9-22-20; -10 years old:

-admitted 7-10-20; -9 years old;

-admitted 2-9-21; -9 years old;

of Bipolar I.

cottage revealed:

Division of Health Service Regulation

afternoons;

STATE FORM 6899 LH9W11 If continuation sheet 2 of 5

PRINTED: 03/22/2021

Division of Health Service Regulation						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL0601226	B. WING		03/1	18/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
PEACE CO	OTTAGE		NT PETER'S LA	NE, SUITE 200		
		MAITHE	WS, NC 28105			
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	TION SHOULD BE COMPLETE THE APPROPRIATE DATE	
V 315	Continued From page	÷ 2	V 315			
		t really sure, but when we go or 3 staff in the cottage."				
	Interview on 2-22-21 with Client #2 revealed: -noticed up to 4 staff when she was awakened in					
	the mornings; -had noticed 1 staff w	orking on occasion but it				
	was not often and it w	vas a long time ago;				
	-2 or 3 staff work in th	ne afternoons and overnight.				
		with Client #3 revealed: re were 1,2,3 or 4 staff				
	-sometimes there was	s 1 staff working when Client				
	#3 woke up in the mo					
	evenings, or overnigh	during the afternoons, nts.				
	Interview on 3-5-21 w					
		rough the grapevine that from other cottages;"				
	_	n the floor by myself."				
		• •				
	Interview on 3-3-21 w	vith Staff #2 revealed: ny responsibility but once I				
	_	he program supervisor looks				
	over it;"					
		shifts when there were staff				
	vacancies throughout	e shift, either the other floor				
		will work the shiftwe can't				
		rtime hecause we are				

Division of Health Service Regulation

staff;

hourly;"

on shift;"

-"staff call outs, short staffed, and COVID-19 are reasons why there have been times with 1 staff

-the attendance policy had been reviewed with

-staffing had improved since they hired another

floor supervisor to assist with staffing.

STATE FORM 6899 LH9W11 If continuation sheet 3 of 5

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Division of Health Service Regulation

Division of	of Health Service Regu	ilation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		MUL 0004220	B. WING		004	0/0004
		MHL0601226			03/1	8/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
DE 4 0E 0	OTT4 OF	6750 SAI	NT PETER'S LA	NE, SUITE 200		
PEACE CO	DITAGE	MATTHE	WS, NC 28105			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
				BEI IGIEROT)		
V 315	Continued From page	e 3	V 315			
	Interview on 0 4 04 w	ith Ctaff #2 may all di				
	Interview on 3-1-21 w					
	-worked by herself for					
		iting for a staff to come in				
	after 3rd shift left wor					
	-"I was on the unit by					
	-never had to work a	•				
		ns, the supervisors had g staffing in the cottages.				
	locused on increasing	g stailing in the cottages.				
	Interview on 3-4-21 w	vith Staff #4 revealed:				
	_	or 3 staff on all shifts;				
		s when the cottage was				
	short staffed;	gg-				
	,	r] had a handle on staffing				
		ome suggestions from staff;				
		n 3rd shift last week but the				
		ed that my co-worker didn't				
	•	isor came over and worked				
	with me through the r					
		a shift, only when someone				
	calls out."	•				
	Interview on 3-8-21 w	vith Staff #5 revealed:				
	,	erself since Christmas;				
	•	cently hired more staff and it				
	had been helpful on 2					
		s 1 staff at the start of 1st				
		r from the time 3rd shift left				
	work and 1st shift arri					
		ours between 3rd shift and				
	1st shift which allowe	d for a staffing shortage.				
	Interview on 2 2 24 ···	with Stoff #6 royonlad:				
	Interview on 3-2-21 w					
		ed to work on 2nd shift;				
		ere short staffed and I had to				
	work with 1 staff on d					
	-would start the shift I					
	-3rd shift would stagg					
	- can t remember the	last date that I worked by				

Division of Health Service Regulation

STATE FORM 6899 LH9W11 If continuation sheet 4 of 5

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		MHL0601226	B. WING		03/1	8/2021		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE				
PEACE CO	OTTAGE		NT PETER'S LA	NE, SUITE 200				
		MATTHE	WS, NC 28105					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPER DEFICIENCY)	BE	(X5) COMPLETE DATE		
V 315	Continued From page	÷ 4	V 315					
	myself on the shift, it has been a while backat least 2 months ago."							
	Interview on 3-9-21 with the Program Supervisor revealed: -the floor supervisors completed the monthly staff schedules and submitted to him for review; -reached out to PRN staff or regular staff to cover for vacancies in the schedule; -staff should notify the facility within an 8 hour window when calling out of work; -the Floor Supervisors, the Program Supervisor, or Director had worked the floor due to staff vacancies; -"was not aware of any time that staff had to work the floor by themselves."							
	-the Floor Supervisors and submitted the sch Supervisors for review -the Floor Supervisor coverage could not be -"ask the staff to give are calling out of work-was not aware of any schedules; -"not aware of any sta	s made the staff schedules nedules to the Program v each month; should step in if staff e located; us an 8 hour notice if they						

Division of Health Service Regulation

STATE FORM 6899 LH9W11 If continuation sheet 5 of 5