Division of Health Service Regulation

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1		(X3) DATE SURVEY COMPLETED	
		A. BUILDING: _			
	MHL013090	B. WING		04/07/2021	
ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MENT STREET			E SW		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	E
INITIAL COMMENTS		V 000			
complaint was unsub	stantiated. (Intake				
category: 10A NCAC	27G .1700 Residential				
		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					
	ROVIDER OR SUPPLIER SUMMARY ST. (EACH DEFICIENC' REGULATORY OR I INITIAL COMMENTS A complaint survey w complaint was unsub- #NC175761). Deficient This facility is license- category: 10A NCAC Treatment Staff Secu- Adolescents G.S. 131E-256(G) HC Allegations, & Protect G.S. §131E-256 HEAR REGISTRY (g) Health care faciliti Department is notified health care personne unknown source, which any act listed in subdi (which includes: a. Neglect or abuse facility or a person to as defined by G.S. 13 b. Misappropriation of in a health care faciliti (b) of this section incl care services as defined by G.S. 13 b. Misappropriation of in a health care facility (c) of this section incl care services as defined by G.S. 13 b. Misappropriation of in a health care facility (d) Diversion of drugs facility or to a patient e. Fraud against a h a patient or client for a providing services).	MHL013090 ROVIDER OR SUPPLIER STREET AD MENT STREET SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS A complaint survey was completed on 4/7/21. The complaint was unsubstantiated. (Intake #NC175761). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents 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. 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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).	MHL013090 MHL013090 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 174 TOURNAMENT DRIVE SW CONCORD, NC 28027 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) REGULATORY OR LSC IDENTIFYING INFORMATION) INTIAL COMMENTS A complaint survey was completed on 4/7/21. The complaint was unsubstantiated. (Intake #NC175761). Deficiencies were cited. This facility is licensed for the following service category: 10A NGAC 27G. 1700 Residential Treatment Staff Secure for Children or Adolescents 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-201 are being provided. b. Misappropriation of the property of a resident in a health care facility. as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a health care facility. d. Diversion of drugs belonging to a health care facility or a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing, so the provides.	DENTIFICATION NUMBER MHILOTIONS MHILOTIONS MHILOTIONS MHILOTIONS MHILOTIONS MHILOTIONS MHILOTIONS MINIMARY STATEMENT OF DEFICIENCES GEACH DEFICIENCY JUST AT PRECEDED BY FLUL REGULATORY OR I.S. CIDENTIFY NO INFORMATION) MINIMARY STATEMENT OF DEFICIENCES GEACH DEFICIENCY MUST AS PRECEDED BY FLUL REGULATORY OR I.S. CIDENTIFY NO INFORMATION) MINITIAL COMMENTS A complaint survey was completed on 4/7/21. The complaint was unsubstantiated. (Intake ##NC175761). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G - 1700 Residential Treatment Staff Secure for Children or Adolescents G.S. 313E-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 penson to whom home care services as defined by G.S. 131E-136 or hospice services 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 or of a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is provided, so the provides, and the property of a healthcare facility or do in the property of a resident or client for whom the employee is provided, so the provides, and the provides

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

TITLE (X6) DATE

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE	SURVEY PLETED
		MHL013090	B. WING		04	/07/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
TOURNAM	MENT STREET		RNAMENT DRIVE	SW		
	I		RD, NC 28027			1
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 132	gonimusu pugu	e 1 and must make every effort	V 132			
	to protect residents from investigation is in programmer investigations must be	om harm while the gress. The results of all e reported to the e working days of the initial				
	facility failed to ensure notified of all allegation personnel and failed to alleged acts were involved. Review on 4/6/21 of co-admission date of 11 diagnoses of Attention Oppositional Defiant In Disorder. Review on 4/6/21 of the Professional/House Morevealed: -date of hire 8/2/17; -documentation of con Aid/CPR(cardiopulmostic)	iew and interviews, the e the Department was ans against health care to have evidence that all estigated. The findings are: client #1's record revealed: /25/20; an Deficit Disorder, Disorder and Adjustment the Qualified Manager (QP/HM)'s record mpleted training in First mary resuscitation) dated				
		dministration dated 1/30/21				

Division of Health Service Regulation

STATE FORM SLXY11 If continuation sheet 2 of 11

Division of	of Health Service Regu	lation			1 0111	IAITROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE S COMPLI	
		MHL013090	B. WING		04/0	7/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
TOURNAM	MENT STREET		RNAMENT DRIV RD, NC 28027	E SW		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL 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 132	Continued From page	e 2	V 132			
	Interventions) dated 1	1/30/21.				
	-Client #1 was found beside the school; -Client #1 was in the -School had a good roward results and re	elationship with the church; nool and client #1 was a ; t #1 to the school; me to school that morning stor of the church; nother client had run away a e facility and staff at the nt #1 if he had anything to do g to "beat his a**;" s frightened; ff had heard any type of #1 regarding any facility staff. with the QP/HM revealed: _(absent without leave) on ulated by former client at his school on 3/23/21; #1's probation officer;				

threatened him;

worked with client #1;

3/23/21 from the school.

-felt safe at the facility; -staff treated him "fine;"

-the QP/HM denied he threatened client #1; -the QP/HM reported he had no contact with client #1 since Friday 3/19/21 when he last

-client #1 was brought back to the facility on

Interview on 3/30/21 with client # revealed:

STATE FORM SLXY11 If continuation sheet 3 of 11

Division	of Health Service Regu	liation	_			
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPL	ETED
			D WING	P WING		
		MHL013090	B. WING		04/0	7/2021
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TWAINE OF TH	NOVIDER OR GOLT EIER					
TOURNAM	MENT STREET		NAMENT DRIV	E SW		
		CONCORI	D, NC 28027			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
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TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DATE
				52.16.2.16.7		
V 132	Continued From page	e 3	V 132			
	. •					
		made threats to him;				
	-denied any staff had	told him they would beat				
	him up.					
		nd 4/6/21 of the facility				
		1/1/21-3/30/21 revealed no				
	incident reports of alle	egations of abuse, neglect or				
	exploitation of clients	by staff.				
	Interviews on 4/6/21	and 4/7/21 with the				
	Licensee/President re	evealed:				
	-did not have any inte	ernal investigations regarding				
	allegations of of abus	e, neglect or exploitation of				
	clients by staff from 1	/1/21-3/30/21;				
	-was told about the in	cident regarding client #1				
	"very loosely" by the	QP/HM;				
		e of the information as				
	reported allegations of	of abuse, neglect or				
	exploitation against s					
	,					
\/ 210	120 0102 4000 2	4 Hour Poporting	V 318			
V 310	130 .0102 HCPR - 24	+ Hour Reporting	V 316			
	10A NCAC 13O .010	2 INVESTIGATING AND				
		H CARE PERSONNEL				
		th care facilities to the				
	•	gations against health care				
		in G.S. 131E-256 (a)(1),				
	~ -	nknown source, shall be				
		of the health care facility				
	_	he allegation. The results of				
	_	y's investigation shall be				
	submitted to the Depart	artment in accordance with				
	G.S. 131E-256(g).					
			1			

Division of Health Service Regulation

STATE FORM SLXY11 If continuation sheet 4 of 11

	of Health Service Regu FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLI	ETED
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		MHL013090	B. WING		04/0	7/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
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	T		D, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 318	Continued From page	e 4	V 318			
	facility failed to ensure health care personne Department (HCPR) we care facility becoming The findings are: Review on 4/6/21 of cadmission date of 11 diagnoses of Attention Oppositional Defiant In Disorder. Review on 4/6/21 of the Professional/House Marevealed: date of hire 8/2/17; documentation of contained and EBPI (Evidence Interventions) dated for Interview on 3/30/21 and EBPI (Evidence Interventions) dated for Interview on 3/30/21 and EBPI (Evidence Interventions) dated for Interview on 3/30/21 and EBPI (Evidence Interventions) dated for Interview on 3/30/21 and EBPI (Evidence Interventions) dated for Interview on 3/30/21 and EBPI (Evidence Interventions) dated for Interview on 3/30/21 and EBPI (Evidence Interventions) dated for Interview on 3/30/21 and EBPI (Evidence Interventions) dated for Interview on 3/30/21 and EBPI (Evidence Interventions) dated for Interview on 3/30/21 and EBPI (Evidence Interventions) dated for Interview on 3/30/21 and EBPI (Evidence Interventions) dated for Interventions dated for Inter	riew and interviews, the e all allegations against I was reported to the within 24 hours of the health g aware of the allegation. client #1's record revealed: /25/20; on Deficit Disorder, Disorder and Adjustment the Qualified Manager (QP/HM)'s record mpleted training in First chary resuscitation) dated dministration dated 1/30/21 Based Protective I/30/21. with a school staff revealed: by the pastor of the church church parking lot; elationship with the church; nool and client #1 was a if #1 to the school; me to school that morning stor of the church; nother client had run away a e facility and staff at the ut #1 if he had anything to do				

Division of Health Service Regulation

STATE FORM SLXY11 If continuation sheet 5 of 11

Division of	of Health Service Regu	lation			TORWALTROV	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL013090	B. WING		04/07/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
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(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 APPROPE DEFICIENCY)	BE COMPLET	E
V 318	Continued From page	5	V 318			
		f had heard any type of				
		the facility staff. I regarding any facility staff. With the QP/HM revealed:				
		(absent without leave) on				
	,	lated by former client				
	-client #1 showed up	at his school on 3/23/21; #1's probation officer;				
	-the probation officer	told the QP/HM client #1 OL because the QP/HM				
	threatened him;	e threatened client #1;				
		he had no contact with 3/19/21 when he last				
	worked with client #1;					
	3/23/21 from the scho					
	Interview on 3/30/21 v					
	-staff treated him "fine -denied any staff had	e;"				
		told him they would beat				
	incident reports from	nd 4/6/21 of the facility 1/1/21-3/30/21 revealed no 4 hour report to HCPR				

regarding allegations of abuse, neglect or exploitation of client #1 by the QP/HM.

Interviews on 4/6/21 and 4/7/21 with the

clients by staff from 1/1/21-3/30/21;

-did not have any internal investigations regarding allegations of of abuse, neglect or exploitation of

-was told about the incident regarding client #1

Licensee/President revealed:

STATE FORM SLXY11 If continuation sheet 6 of 11

Division of	of Health Service Regu	ation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		MHL013090	B. WING		04/07/2021	
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TVAINE OF T	NOVIDEN ON GOLT EIEN		RNAMENT DRIV			
TOURNAM	MENT STREET		D, NC 28027	2011		
(VA) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CORRECTION	d ov	5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DA	TE
				DEFICIENCY)		
V 318	Continued From page	: 6	V 318			
	"very loosely" by the	OP/HM:				
	-was not made aware					
	reported allegations o					
	exploitation against st					
V 367	27G .0604 Incident R	eporting Requirements	V 367			
	10A NCAC 27G .0604	INCIDENT				
	REPORTING REQUI					
	CATEGORY A AND B					
		providers shall report all				
		ept deaths, that occur during				
		e services or while the				
	consumer is on the pr	oviders premises or level III				
	incidents and level II	deaths involving the clients				
		rendered any service within				
	90 days prior to the in					
	responsible for the ca					
	services are provided					
		e incident. The report shall				
	be submitted on a for	m provided by the t may be submitted via mail,				
	in person, facsimile o					
		nall include the following				
	information:	9				
		ovider contact and				
	identification informat					
		ication information;				
	(3) type of incid					
	(4) description					
	(-)	e effort to determine the				
	cause of the incident;	and				

(6)

or responding.

day whenever:

other individuals or authorities notified

(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

STATE FORM 6899 SLXY11 If continuation sheet 7 of 11

Division of Health Service Regulation

DIVISION	n nealth Service Negu	ialion			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED	
	MHL013090 B. WIN		B. WING		04/07/2021
		WITEUTSUSU			04/07/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
TOURNAS	MENT STREET	174 TOUR	NAMENT DRIV	E SW	
IOURNAI	MENT SINCE	CONCOR), NC 28027		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I (X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE DATE
				,	
V 367	Continued From page	2 7	V 367		
	(1) the provider	has reason to believe that			
	information provided	in the report may be			
	erroneous, misleading	g or otherwise unreliable; or			
	(2) the provider	obtains information			
	required on the incide	ent form that was previously			
	unavailable.				
		providers shall submit,			
		ME, other information			
	obtained regarding th				
	, ,	ords including confidential			
	information;				
		ther authorities; and			
	. ,	's response to the incident.			
	` ,	providers shall send a copy			
		reports to the Division of			
	The state of the s	opmental Disabilities and			
		rvices within 72 hours of			
	•	e incident. Category A			
	providers shall send a	• •			
	_	client death to the Division of			
		ation within 72 hours of le incident. In cases of			
	•	ven days of use of seclusion			
		der shall report the death			
	· ·	red by 10A NCAC 26C			
	.0300 and 10A NCAC	•			
		s providers shall send a			
	` ,	LME responsible for the			
		e services are provided.			
		ibmitted on a form provided			
		electronic means and shall			
	include summary info				
	-	errors that do not meet the			
	definition of a level II	or level III incident;			
		terventions that do not meet			
		el II or level III incident;			
	(3) searches of	a client or his living area;			
		client property or property in			
	the possession of a c				

Division of Health Service Regulation

STATE FORM SLXY11 If continuation sheet 8 of 11

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		MHL013090	B. WING		04	/07/2021
	ROVIDER OR SUPPLIER	174 TOL	ADDRESS, CITY, STATE IRNAMENT DRIVE RD, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 367	incidents that occurre (6) a statement been no reportable in incidents have occurr meet any of the criter (a) and (d) of this Rul through (4) of this Pa	mber of level II and level III ed; and t indicating that there have acidents whenever no red during the quarter that ria as set forth in Paragraphs te and Subparagraphs (1) ragraph.	V 367			
	facility failed to ensurincidents were report for the catchment are provided within 72 ho the incident. The allegangles of the incident. The allegangles of Attention of the incident of the i	view and interviews, the e all level II and level III ed to the LME responsible ea where services are ours of becoming aware of gations are: client #1's record revealed: 1/25/20; on Deficit Disorder, Disorder and Adjustment che Qualified Manager (QP/HM)'s record mpleted training in First onary resuscitation) dated dministration dated 1/30/21				

Division of Health Service Regulation

STATE FORM SLXY11 If continuation sheet 9 of 11

Division o	of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPL	ETED	
			- T			
			P WING			
		MHL013090	B. WING		04/0	7/2021
NAME OF PE	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE		
	1011211 011 001 1 21211		, ,	,		
TOURNAM	MENT STREET		RNAMENT DRIV	E 3W		
		CONCOR	D, NC 28027			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
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TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	KIATE	DATE
				DEI IOIENOT)		
V 367	Continued From page	<u> 9</u>	V 367			
	Continuou i rom page	3.0				
	Interview on 3/30/21	with a school staff revealed:				
	-Client #1 was found	by the pastor of the church				
	beside the school;					
	-Client #1 was in the	church parking lot:				
		elationship with the church;				
	•	nool and client #1 was a				
	student at the school;					
	-Pastor brought client					
	•	me to school that morning				
		•				
	but came with the pas					
	•	nother client had run away a				
		e facility and staff at the				
		nt #1 if he had anything to do				
	with it, staff was going	•				
	-Client #1 said he was					
	-First time school staf	ff had heard any type of				
	allegations by client #	t1 regarding any facility staff.				
	Interview on 3/30/21 v	with the QP/HM revealed:				
		(absent without leave) on				
	3/21/21;	e(absent without leave) on				
	-	ulated by former client				
	#3(FC#3);	diated by former chefit				
	, , ,	at his school on 3/23/21;				
	-QP called client #1's	•				
		,				
	-the probation officer					
	reported he went AW	OL because the QP				
	threatened him;					
	-the QP denied he thr					
	-the QP reported he h	nad no contact with client #1				
	since Friday 3/19/21	when he last worked with				
	client #1;					
	-client #1 was brough	t back to the facility on				
	3/23/21 from the scho					
	Interview on 3/30/21	with client # revealed:				
	-felt safe at the facility					
	-staff treated him "fine					
	Stan a Cateu mini min	٠,	1			1

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-denied any staff had made threats to him; -denied any staff had told him they would beat

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		MHL013090	B. WING		04/07/202	1
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
TOURNA	MENT STREET	174 TOUR	NAMENT DRIV	ESW		
		CONCORE	, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COM	X5) IPLETE ATE
V 367	Continued From page	e 10	V 367			
	him up.					
	incident reports from 2/7/21 client #1 went 2/7/21 client #2 went 2/7/21 FC #4 went AV 3/21/21 client #1 wen 3/21/21 FC #3 went AV No incident reports of neglect or exploitation Interview on 4/7/21 wrevealed: -was told about the in QP/HM regarding clie	AWOL; WOL; at AWOL; aWOL. f allegations of of abuse, n of clients by staff. with the Licensee/President acident "very loosely" by the ent #1; e of the information as of abuse, neglect or				

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