

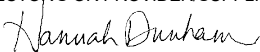
Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL0601226</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/18/2021</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PEACE COTTAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6750 SAINT PETER'S LANE, SUITE 200 MATTHEWS, NC 28105</b>
--	---

(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	<b>INITIAL COMMENTS</b>  A complaint survey was completed on March 18, 2021. The complaint was substantiated (Intake #NC 00173789). A deficiency was cited.  The facility is licensed for the following service category: 10A NCAC 27G. 1900 Psychiatric Residential Treatment for Children and Adolescents.	V 000		
V 315	27G .1902 Psych. Res. Tx. Facility - Staff  10A NCAC 27G .1902 STAFF (a) Each facility shall be under the direction a physician board-eligible or certified in child psychiatry or a general psychiatrist with experience in the treatment of children and adolescents with mental illness. (b) At all times, at least two direct care staff members shall be present with every six children or adolescents in each residential unit. (c) If the PRTF is hospital based, staff shall be specifically assigned to this facility, with responsibilities separate from those performed on an acute medical unit or other residential units. (d) A psychiatrist shall provide weekly consultation to review medications with each child or adolescent admitted to the facility. (e) The PRTF shall provide 24 hour on-site coverage by a registered nurse.  This Rule is not met as evidenced by: Based on record reviews, interviews, and observations, the facility failed to ensure that two direct care staff were present with every 6	V 315	v315 - 1 - Chief of Programs created a group staffing concerns email address to encourage staff to submit any concerns related to staffing/ratio. All residential staff were informed of new avenue to voice concerns. 2-VP of Residential Services created new policy specific to ratio and distributed to all residential staff. 3- VP of Residential/Program Director trained program supervisors on the following: ratio, administrator on call, scheduling, supervision and attendance. 4-Program Supervisors trained all residential care specialist on the following policies: ratio, administrator on call, scheduling, supervision, and attendance. 5 - Program Director instituted daily staffing calls with supervisors. 6- Program Director conducts bi-weekly camera review across shifts to ensure ratio is met.	3/12/21        3/12/21        3/16/21        3/26/21        3/10/21, ongoing        3/15/21, ongoing

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



TITLE (X6) DATE

**Chief Performance & Quality Officer 5/4/21**

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL0601226</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/18/2021</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PEACE COTTAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6750 SAINT PETER'S LANE, SUITE 200 MATTHEWS, NC 28105</b>
--	---

(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 315	<p>Continued From page 1</p> <p>children or adolescents in each residential unit. The findings are:</p> <p>Review on 2-23-21 of Client #1's record revealed: -admitted 9-22-20; -10 years old; -diagnosed with Post Traumatic Stress Disorder, Chronic Anxiety, and Major Depression.</p> <p>Review on 2-23-21 of Client #2's record revealed: -admitted 7-10-20; -9 years old; -diagnosed with Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Generalized Anxiety disorder, Post Traumatic Stress Disorder, and Schizoaffective Disorder.</p> <p>Review on 2-23-21 of Client #3's record revealed: -admitted 2-9-21; -9 years old; -diagnosed with Reactive Attachment Disorder, Attention Deficit Hyperactivity Disorder, Generalized Anxiety Disorder, Borderline Intellectual Functioning, and Provisional diagnosis of Bipolar I.</p> <p>Observation at 10:10am on 2-22-21 of the cottage revealed: -5 female clients were in the cottage; -3 female staff members were on duty in the cottage; -the clients and staff were leaving the cottage for school at the time of the observation.</p> <p>Interview on 2-22-21 with Client #1 revealed: -2 or 3 staff worked when Client #1 was awakened in the morning; -there were 2, 3, or 4 staff working in the afternoons; -"during the night I think 1 staff works while we</p>	V 315	<p>V315 continued...</p> <p>7 - Program supervisors publish schedules on consistent scheduling platform (Teams) that is accessible to all residential employees and leadership.</p> <p>8- Program Director to complete weekly skip level interviews with residential care specialists.</p> <p>Monitor progress with the POC during weekly POC meeting with PQI, Program Director and VP of Residential services to review staff/scheduling and monitoring of POC.</p>	<p>3/29/21</p> <p>3/29/21</p> <p>3/15/21</p>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL0601226</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/18/2021</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PEACE COTTAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6750 SAINT PETER'S LANE, SUITE 200 MATTHEWS, NC 28105</b>
--	---

(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 315	<p>Continued From page 2</p> <p>are asleep but I'm not really sure, but when we go to sleep there are 2 or 3 staff in the cottage."</p> <p>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 working on occasion but it was not often and it was a long time ago; -2 or 3 staff work in the afternoons and overnight.</p> <p>Interview on 2-22-21 with Client #3 revealed: -in the mornings, there were 1,2,3 or 4 staff working; -sometimes there was 1 staff working when Client #3 woke up in the mornings; -never noticed 1 staff during the afternoons, evenings, or overnights.</p> <p>Interview on 3-5-21 with Staff #1 revealed: -"somedays I hear through the grapevine that they are short staffed from other cottages;" -"I have not worked on the floor by myself."</p> <p>Interview on 3-3-21 with Staff #2 revealed: -"scheduling staff is my responsibility but once I make the schedule, the program supervisor looks over it;" -had worked to fill in shifts when there were staff vacancies throughout the month; -"if no one accepts the shift, either the other floor supervisor or myself will work the shift...we can't exceed 20 hours overtime because we are hourly;" -"staff call outs, short staffed, and COVID-19 are reasons why there have been times with 1 staff on shift;" -the attendance policy had been reviewed with staff; -staffing had improved since they hired another floor supervisor to assist with staffing.</p>	V 315		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL0601226</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/18/2021</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PEACE COTTAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6750 SAINT PETER'S LANE, SUITE 200 MATTHEWS, NC 28105</b>
--	---

(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 315	<p>Continued From page 3</p> <p>Interview on 3-1-21 with Staff #3 revealed: -worked by herself for 1 hour this morning because she was waiting for a staff to come in after 3rd shift left work; -"I was on the unit by myself with 5 girls;" -never had to work a full shift by herself; -over the last 2 months, the supervisors had focused on increasing staffing in the cottages .</p> <p>Interview on 3-4-21 with Staff #4 revealed: -there were usually 2 or 3 staff on all shifts; -there had been times when the cottage was short staffed; -[Program Supervisor] had a handle on staffing and had listened to some suggestions from staff; -"worked by myself on 3rd shift last week but the supervisor was notified that my co-worker didn't arrive and the supervisor came over and worked with me through the night;" -"rare to be alone on a shift, only when someone calls out."</p> <p>Interview on 3-8-21 with Staff #5 revealed: -had not worked by herself since Christmas; -management had recently hired more staff and it had been helpful on 2nd and 3rd shift; -sometimes there was 1 staff at the start of 1st shift for about an hour from the time 3rd shift left work and 1st shift arrived to work; -there was a gap in hours between 3rd shift and 1st shift which allowed for a staffing shortage .</p> <p>Interview on 3-2-21 with Staff #6 revealed: -2 staff were scheduled to work on 2nd shift; -"quite recently we were short staffed and I had to work with 1 staff on duty for part of a shift" -would start the shift by myself; -3rd shift would stagger with 2nd shift; -"can't remember the last date that I worked by</p>	V 315		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL0601226</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/18/2021</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PEACE COTTAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6750 SAINT PETER'S LANE, SUITE 200 MATTHEWS, NC 28105</b>
--	---

(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 315	<p>Continued From page 4</p> <p>myself on the shift, it has been a while back...at least 2 months ago."</p> <p>Interview on 3-9-21 with the Program Supervisor revealed:</p> <ul style="list-style-type: none"> <li>-the floor supervisors completed the monthly staff schedules and submitted to him for review;</li> <li>-reached out to PRN staff or regular staff to cover for vacancies in the schedule;</li> <li>-staff should notify the facility within an 8 hour window when calling out of work;</li> <li>-the Floor Supervisors, the Program Supervisor, or Director had worked the floor due to staff vacancies;</li> <li>-"was not aware of any time that staff had to work the floor by themselves."</li> </ul> <p>Interview on 3-9-21 with the Director revealed:</p> <ul style="list-style-type: none"> <li>-the Floor Supervisors made the staff schedules and submitted the schedules to the Program Supervisors for review each month;</li> <li>-the Floor Supervisor should step in if staff coverage could not be located;</li> <li>-"ask the staff to give us an 8 hour notice if they are calling out of work"</li> <li>-was not aware of any holes in the staff schedules;</li> <li>-"not aware of any staff that have worked on the floor by themselves in January and February 2021."</li> </ul>	V 315		