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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL'S ANGEL CARE, INC	1423 GRANDVIEW DRIVE FAYETTEVILLE, NC 28314

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on October 1, 2021. The complaint was substantiated (Intake #NC00179530). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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V 112	Continued From page 1	V 112		

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to develop and implement strategies to address client needs for 1 of 3 audited clients (#2). The findings are:

Review on 9/30/21 and 10/01/21 of client #2's record revealed:
-17 year-old male.
-Admission date of 2/28/21.
- Diagnoses included attention deficit hyperactive disorder (ADHD)- combined type severe, disruptive mood dysregulation disorder (DMDD) , conduct disorder, oppositional defiant disorder (ODD), posttraumatic stress disorder (PTSD), adjustment disorder, and reactive attachment disorder.
-No notes on client #2's record from a therapist.

Review on 9/30/21 and 10/01/21 of client #2's treatment plan dated 9/23/21 revealed:
-7/14/21 notes documented client #2 eloped in July 2021 aided by his siblings because he wanted to see his mother. The client had no memory of his parents. He admitted to using marijuana while he eloped.
-8/17/21 note documented client #2 would turn 18 years old on 10/18/21. Client #2 was not receptive to a program following his discharge from the facility; his goal was to live with his mother.
-9/23/21 note documented client #2 had 2 assessments with his probation officer and had requirements to pay fines and community service

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V 112	Continued From page 2	V 112		

by March 2022.
-There were no client goals developed to address client #2's needs for independent living skills if he chose to discharge on his 18 th birthday.
-There were no goals developed to address substance abuse issues.
-"Action Plan" notes dated 2/18/21, 4/20/21, 5/20/21, 6/14/21, 7/14/21, 8/17/21, 9/23/21 document client #2 had been "linked" with outpatient therapy.
-All goals listed "Therapists" as a responsible party and strategies included 90 minutes of therapy a week.

Interview on 9/30/21 client #2 stated:
-He was to turn 18 years old in 2 weeks and was "headed back" to live with his mother.
-A therapists would talk to the clients every month on line.
-He did not have any other therapy or counseling in addition to the online monthly meeting.
-He could not recall the name of the on line counselor/therapist.
-He saw a doctor every month about his medications.

Interview on 10/1/21 the LP stated:
-He did not provide individual therapy services for client #2 because he (client #2) had a different funding source than what he (LP) worked with.
-He did provide individual therapy services for client #1.
-He did not know who provided individual therapy services for client #2.
-He attended CFTs (Child Family Team Meetings) and provided group therapy for both clients once a month.

Interview on 10/1/21 the Licensee stated:
-She thought client #2 was receiving therapy from

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V 112	Continued From page 3 the LP. -She would have the LP and Qualified Professional work out the roles and responsibilities.	V 112		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118		

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V 118	Continued From page 4 This Rule is not met as evidenced by: Based on record reviews, interviews and observations, the facility failed to administer medications on the written order of a physician and failed to keep the MARs current affecting 2 of 2 current clients audited (#1, #2). The findings are: Finding #1: Review on 9/30/21 and 10/01/21 of client #1's record revealed: -15 year-old male. -Admission date of 5/07/21. -Diagnoses included conduct disorder, attention deficit hyperactive disorder (ADHD)- combined type severe, and disruptive mood dysregulation disorder (DMDD). Review on 9/30/21 and 10/01/21 of client #1's medication order dates and orders revealed: -6/23/21 and 9/9/21: Guanfacine HCL (hydrochloride) ER (extended release) 1 mg (milligram) twice daily. (ADHD) -9/9/21: Aripiprazole 5 mg daily. (Antipsychotic, depression) -8/3/21: Concerta 36 mg every morning. (ADHD) -9/9/21: Discontinue Concerta 36 mg. -9/9/21: Concerta ER 54 mg daily in the morning. (increased to improve concentrtion and decease impulsivity) -6/23/21 and 9/9/21: Oxtellar XR (extended release) 300 mg twice daily. (Anticonvulsant) -No order in client #1's record to decrease Guanfacine HCL 1 mg from twice daily to once daily on 8/19/21.	V 118		

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V 118	Continued From page 5 -No order in client #1's record for Abilify 5 mg daily prior to the order dated 9/9/21. -No order in client #1's record to discontinue Oxtellar XR 300 mg twice daily on 8/17/21. Review on 9/30/21 and 10/01/21 of client #1's July, August, September, and October 2021 MARS revealed: 1. October 2021 MAR: -Aripiprazole 5 mg daily scheduled for 7 am was not documented given on 10/1/21. 2. September 2021 MAR: -Guanfacine 1 mg tablet once a day was transcribed on the MAR and documented as given from 9/1/21 - 9/30/21. -Concerta 36 mg every morning was not transcribed to the MAR and not documented as given 9/1/21 - 9/9/21 prior to being discontinued 9/9/21. -Aripiprazole 5 mg daily was not transcribed to the MAR and not documented as given 9/1/21 - 9/30/21. 3. August 2021 MAR: -Guanfacine 1 mg tablet once a day was transcribed on the MAR and documented as given from 8/19/21 - 8/30/21. -No Guanfacine 1 mg was docmented on 8/18/21. -Aripiprazole 1 mg administered daily from 8/5/21 - 8/31/21. -Oxtellar XR 300 mg twice daily was discontinued on the MAR 8/17/21; none was administered 8/18/21 - 8/31/21. Interview on 9/30/21 client #1 stated he received his medications as ordered. Finding #2: Review on 9/30/21 and 10/01/21 of client #2's record revealed:	V 118		

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V 118	Continued From page 6 -17 year-old male. -Admission date of 2/28/21. - Diagnoses included DMDD, ADHD, conduct disorder, oppositional defiant disorder (ODD), posttraumatic stress disorder (PTSD), adjustment disorder, and reactive attachment disorder. Review on 9/30/21 and 10/01/21 of client #2's medication order dates and orders revealed: -5/12/21 and 6/9/21: Melatonin 10 mg at night. (Insomnia) -3/10/21: Melatonin 5 mg at bedtime as needed for insomnia. -3/10/21: Gavilax 238g (grams) 17g mixed in 8 ounces of beverage on Monday, Wednesday, and Friday at 2 pm. (Constipation) Review on 9/30/21 and 10/01/21 of client #2's July, August, September, and October 2021 MARS revealed: 1. September and October 2021 MARs: -Gavilax 238g (grams) 17g mixed in 8 ounces of beverage on Monday, Wednesday, and Friday scheduled to be administered at 7 pm. 2. August 2021 MAR: -"Melatonin 5 mg. Take 1 tablet by mouth at bedtime," Time "PRN," transcribed and documented as given 8/1/21 - 8/30/21. -Gavilax 238g (grams) 17g mixed in 8 ounces of beverage on Monday, Wednesday, and Friday at 2 pm was not transcribed to the MAR; not documented as given 8/1/21 - 8/30/21. -"Miralax Powder (Polyethylene Glycol 3350)," Time PRN," transcribed to the MAR; none had been documented as given 8/1/21 - 8/30/21. 3. July 2021 MAR: -"Melatonin 5 mg. Take 1 tablet by mouth at bedtime," Time "PRN," transcribed and documented as given 7/4/21 - 7/31/21. -Order for Gavilax 238g Monday, Wednesday,	V 118		

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V 118	Continued From page 7 and Friday at 2 pm was not transcribed to the MAR given to the surveyors to review. Interview on 9/30/21 client #2 stated: -He saw a physician every month about his medications. -He received his medications at the facility. Interview on 9/30/21 the Associate Professional (AP) stated: -She started as the AP in June 2021. -She took the clients to physician appointments and transcribed the medications ordered to the MARs. Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician. This deficiency has been cited 3 times since the original cite on 12/14/20 and must be corrected within 30 days.	V 118		
V 297	27G .1705 Residential Tx. Child/Adol - Req. for L P 10A NCAC 27G .1705 REQUIREMENTS OF LICENSED PROFESSIONALS (a) Face to face clinical consultation shall be provided in each facility at least four hours a week by a licensed professional. For purposes of this Rule, licensed professional means an individual who holds a license or provisional license issued by the governing board regulating a human service profession in the State of North Carolina. For substance-related disorders this shall include a licensed Clinical Addiction Specialist or a certified Clinical Supervisor.	V 297		

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V 297	Continued From page 8 (b) The consultation specified in Paragraph (a) of this Rule shall include: (1) clinical supervision of the qualified professional specified in Rule .1702 of this Section; (2) individual, group or family therapy services; or (3) involvement in child or adolescent specific treatment plans or overall program issues. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure face to face clinical consultation was provided in the facility at least four hours a week by a Licensed Professional (LP). The findings are: Review on 9/30/21 and 10/01/21 of client #1's record revealed: -15 year-old male. -Admission date of 5/07/21. -Diagnoses included conduct disorder, attention deficit hyperactive disorder (ADHD)- combined type severe, and disruptive mood dysregulation disorder (DMDD). -No documented LP hours available for review. Review on 9/30/21 and 10/01/21 of client #2's record revealed: -17 year-old male. -Admission date of 2/28/21. - Diagnoses included DMDD, ADHD, conduct disorder, oppositional defiant disorder (ODD), posttraumatic stress disorder (PTSD), adjustment disorder, and reactive attachment disorder. -No documented LP hours available for review.	V 297		

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V 297	Continued From page 9 Interview on 9/30/21 client #1 stated: -He did not participate in group counseling. -He met with his therapist once a month. -He could not recall the name of his therapist. -Therapeutic sessions were completed by phone. -He saw the Qualified Professional (QP) once a month. Interview on 9/30/21 client #2 stated: -A therapists would talk to the clients every month on line. -He could not recall the name of his therapist. -Therapeutic sessions were completed by zoom. -He saw the Qualified Professional (QP) two times per week. Interview on 10/01/21 the therapist stated: -He was a licensed clinical social worker. -Since the pandemic he had been conducting therapeutic sessions virtually. -He completed 1 hour per week of individual therapy and 1 hour per month of group therapy for client #1. -He completed 1 hour per month of group therapy and no individual therapy sessions for client #2. -He completed QP supervision. Interview on 9/30/21 and 10/01/21 Associate Professional (AP) stated: -QP conducted peer group meetings twice per month. -She was uncertain how many hours per week/ month the QP spent at the facility. -The therapists for client #1 and client #2 both come to the facility twice a month. Interview on 10/01/21 the Director stated: -She was unaware the therapist was not completing LP requirements.	V 297		

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V 297	Continued From page 10 -She was going to meet with the QP and therapist to clarify individual roles and responsibilities.	V 297		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (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 wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the	V 536		

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V 536	Continued From page 11 following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (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 Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program	V 536		

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aimed at preventing, reducing and eliminating the need for restrictive interventions.
(2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.
(3) 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.
(4) 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 (i)(5) of this Rule.
(5) Acceptable instructor training programs shall include but are not limited to presentation of:
(A) understanding the adult learner;
(B) methods for teaching content of the course;
(C) methods for evaluating trainee performance; and
(D) documentation procedures.
(6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach.
(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.
(8) Trainers shall complete a refresher instructor training at least every two years.
(j) 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

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V 536	Continued From page 13 outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) 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. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure one of three audited staff (#8) were trained and demonstrated competency in alternatives to restrictive interventions. The findings are: Review on 10/01/21 of staff #8's personnel record revealed: -Hire date 9/27/21. Interview on 9/30/21 staff #8 stated: -He had worked with the facility for under a week (9/27/21). -He had never taken any kind of restrictive intervention/de-escalation training. -He had never heard of Nonviolent Crisis	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mhl026-709	A. BUILDING: _____ B. WING _____	R 10/01/2021

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V 536	Continued From page 14 Intervention (NCI) training -He had never worked in the human service field prior to his hire on 9/27/21. -He had never used a restrictive intervention. Interview on 10/01/21 the Director stated: -Staff #8 had been hired on 9/27/21. -Staff #8 had completed NCI+ Restrictive training on 1/05/21 after being considered for hire in December 2020. However, he opted not to take the position after completing a portion of his trainings in January 2021. -Staff #8 must have forgotten he took the training.	V 536		
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 demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of	V 537		

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V 537	Continued From page 15 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 importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain	V 537		

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V 537	Continued From page 16 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; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and	V 537		

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V 537	Continued From page 17 (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 preparation as for trainers.	V 537		

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V 537	Continued From page 18 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure one of three audited staff (#8) were trained and demonstrated competency in seclusion, physical restraint and isolation time-out. The findings are: Review on 10/01/21 of staff #8's personnel record revealed: -Hire date 9/27/21. Interview on 9/30/21 staff #8 stated: -He had worked with the facility for under a week (9/27/21). -He had never taken any kind of restrictive intervention/de-escalation training. -He had never heard of Nonviolent Crisis Intervention (NCI) training -He had never worked in the human service field prior to his hire on 9/27/21. -He had never used a restrictive intervention. Interview on 10/01/21 the Director stated: -Staff #8 had been hired on 9/27/21. -Staff #8 had completed NCI+ Restrictive training on 1/05/21 after being considered for hire in December 2020. However, he opted not to take the position after completing a portion of his trainings in January 2021. -Staff #8 must have forgotten he took the training.	V 537		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be	V 736		

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V 736	Continued From page 19 maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observations on 9/30/21 at approximately 1:00pm revealed: -The two dining room walls behind the dining room table had miscellaneous brown stains and food debris stuck to the wallpaper. -Two light bulbs were missing from the chandelier hanging over the dining room table. -There was a sagging piece of particle wood approximately 12-16" in length on the right side of the roof on the back porch. -The dresser in Client #2 's bedroom had a missing drawer on the lower right side and missing knobs on the upper left side. -The showerhead located in client #1's bathroom was loose from the wall. -The vacant room had broken slats in the blinds of the right side window and a layer of dust on the under side of the ceiling fan. -There was a rusted vent at the end of the hallway approximately 2-3' in length and height. During interview on 9/30/21 the Associate Professional revealed: -She would contact maintenance and ensure maintenance concerns were completed.	V 736		