Division of Health Service Regulation (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: B. WING 10/05/2021 MHL012-137 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 109 PARKER LANE PARK PLACE MORGANTON, NC 28655 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 000 V 000 INITIAL COMMENTS An annual, complaint, and follow up survey was completed on 10/05/2021. The complaint was substantiated (Intake #NC00178144). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents. V 109 V 109 27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures

Division of Health Service Regulation
LABORATORY DIRECTOR'S OF PROVIDER/SURPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

ON THE CONTROL OF TH

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				' '	3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	=1ED
		MHL012-137	B. WING		10/0	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	ATE, ZIP CODE		
PARK PL	ACE	109 PARKI				
		MORGAN	ON, NC 2865	5		
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 109	Communication page	e 1 individualized supervision	V 109			
	plan upon hiring each (g) The associate pro supervised by a quali	associate professional.  ofessional shall be fied professional with the the period of time as				
	Qualified Professional knowledge, skills and population served. The Review on 09/14/202 - Hire date of 09/03/20 - Documentation of course following areas; F (PCP) Training - 7/8/2019, F 8/29/2017 and Child is (CFT) - 2/14/2018 Job Description sign specified: "Oversight or offense specific clicked by an individual position supervised a within their assigned administratively." - Job Duty Description in monitoring the stat treatment goals as our monthly CFT meeting including all safety, a	ews and interviews, 1 of 1 al (QP) failed to demonstrate abilities required by the ne findings are:  1 of QP's record revealed: 010. 010. 010. 0110. 0		Case responsible QP will complete a retraining of PCP guidelines and rule: immediately; this process will be com with either the Program, Clinical and/Director; training will include reoccurr client behaviors that are addressed b and not identified as a need in the PC warrants for goals to be changed, rev and/or added. Lead QP will be retrain exploitation, neglect and abuse due to indirect involvement with client buying Lead QP's daughter's car. Weekly me will begin with Lead QP and Program Director for a minimum of two months will titrate to monthly to oversee concaddressed and general policies and procedures and be tweaked as needed. Case responsible QP completed a reform of PCP guidelines and rules immediathis process was completed with QI Expressed by staff and not identified need in the PCP warrants for goals to changed, revised and/or added; this vaddressed by Program and QI Director October's facility staff meeting.	pleted or QI ing y staff CP ised led in the g the eetings and QI s which eerns ed. training tely; birector. as a be was	12/04/2021

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 2 of 79

Division of Health Service Regulation

AND BLAN OF CORRECTION LIDENTIFICATION NUMBER:		` ′			(3) DATE SURVEY COMPLETED	
		MHL012-137	B. WING		10/0	5/2021
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE ZIP CODE	1 10/0	0/2021
NAME OF T	NOVIDER OR SOLT ELER		KER LANE	N.E., ZII GODE		
PARK PLA	ACE		ITON, NC 2865	5		
(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 APPROPROPERTICENCY)	BE	(X5) COMPLETE DATE
V 109	Continued From page	: 2	V 109			
	Submit incident re Improvement Director verification. Submit le					
	facility incident reports 09/14/2021 revealed: -Incident report regard submitted 06/08/2021 Improvement (QI) Dirac-Sexual Abuse/Assau "Client was approach tried to pull his pants for the client to allow fellatio." -The report indicated incident on 06/08/202	ding Former Client (FC) #6 by the Quality ector. It/Rape was checked: ed by a peer [FC #7] who down and repeatedly asked him to give the client the provider learned of the 1.		QP was provided supervision on 10/0 10/21, 10/26, 10/27 & 10/28. Program Director will continue to work with the continue developing her skills to the F there are significant client behaviors a appropriate incident reporting requirer This is ongoing.	a & QI QP to PCP when and	10/28/2021
	"Client [FC #6] had be by peer [FC #7]."  -The incident prevent not inform staff of the by peer [FC #7]. Clie communicated and reassistance. Client ack of sharing information he feels uncomfortabled -Incident comments be Entity (LME) dated 06 document how the coissues are being addrefer -There were no updat provider after 06/11/202	ached out to staff for knowledged the importance with adults he trusts when e." y the Local Management b/11/2021 were "Please nsumer's health and safety essed." ed comments by the 021.				
	statement signed and regarding the 06/02/2	dated 06/05/2021 021 incident revealed:				

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 3 of 79

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	
		MUI 042 427	B. WING		4.	NOE 12024
		MHL012-137			10	0/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE		
PARK PL	ACE		KER LANE			
.,		MORGAI	NTON, NC 28655			
(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 AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 109	Continued From page	e 3	V 109			
	informed methat he inappropriate act with said, 'he gave me hea	2021 @ 7:30 pm [FC #7] e had been engaged in an that peer [FC #6][FC #7] ad'" and dated the statement on				
	Disorder (ADHD), Pe (dysthymia disorder), Disorder (ODD) -Ado DisorderComprehensive Clin addendum dated 04/0 experiencing frequen setting, consistently overbal aggression cal names; makes threat	1/29/2021. 5/30/2021. on Deficit Hyperactive rsistent Depressive Disorder				
	physically posturing a and where he wants or redirection the curronsists of setting for problem sexualized bhave successfully conclient very aware of the graphic sexualized congestures that would bharassment. Shows mand never apologized sexualized behaviors.  Review on 9/17/21 of	and blocking staff to get what will not follow prompts or rent group home primarily adolescent males with rehaviors (PSBs) after they impleted the PSB program, his yet continues to make omments and physical recharacterized as sexual recommends or his actions so Client laughs at his				
	a summary of [FC #7	's] comments and concerns ne 29th, 2021" revealed:				

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 4 of 79

Division of Health Service Regulation

MHL012-137  A. BUILDING:  B. WING  STREET ADDRESS CITY STATE ZID CODE	10/05/2021
WITEO12-137	10/05/2021
NAME OF DROVIDED OR CURRING	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
PARK PLACE 109 PARKER LANE	
PARK PLACE MORGANTON, NC 28655	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109 Continued From page 4 V 109	
V109  -"[FC #7] makes sexual comments and gestures that appeared to make his peers feel unsafe and uncomfortable."  -"He told a peer that he wanted his oily hands on his body and said, "I like a man with oily hands" twice. Said 'Umm! (after that same peer came out of the bathroom after showering and shaving)."  -"Told staff and peers what he likes put in his buttthat he needs 8 inches."  -"Had saran wrap in his book bag and told staff in front of peers that it was his homemade condom."  -"Several times he talked about anal sex and sticking things in his rear."  -"He said he was going to give a classmate "head" in the bathroom at school"  -"He saked staff and a peer if they knew what fellatio was and if they had ever done that. He asked a peer again that evening if he like fellatio and proceeded to use gestures to explain the meaning of the word when the peer said he didn't know what [Fc #6] meant."  -"Made comments about what sexual positions he likes and said, I want some d"*k. D"*k tastes good."  -"Warning staff to keep a close eye on him because if he was alone with a certain peer, he would grab that peer's butt. It is noted that [FC #7] would sit near the basketball court on a chair and watch that peer while making inappropriate sexual statements that staff could hear in reference to his "crush."  -"Telling another peer what he would like to do to the peer's butt and then saying, 'Umm.' It is noted that [FC #7] appeared to follow this peer around and stand too closely to the peer"  -"[FC #7] sings a lot of inappropriate gestures and dance moves. Twerking, hiking shorts up to	

Division of Health Service Regulation

STATE FORM 6899 NBPP11 If continuation sheet 5 of 79

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		
		MHL012-137	B. WING		10/05/2021	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	10/00/2021	
D4 D14 D1		109 PAR	KER LANE			
PARK PLA	ACE	MORGAN	ITON, NC 28655	i		
(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 SHOUL) CROSS-REFERENCED TO THE APPROFIDERICENCY)	D BE COMPI	LETE
V 109	horseblowing kisse eating finger good in pushing up his breast bounced around his pushing up to [FC #7's] be always be near him to safe"  Review on 09/16/202 revealed: -Admission date of 02-Discharge date of 03-Age 19 yearsDiagnoses of ADHD Anxiety DisorderCCA addendum date "Prior to coming to Foservices (Licensee), with first degree statuengaging in sexually his siblings and misus reoffended in the hon probation and, as a rethe NC Sex Offender	f the couch as if he is on a es at staff, licking his feet, a sexual mannerand its as he danced and opers and staff."  havioral one staff had to be keep him and his peers  1 of FC #8's record  2/28/2020.  3/10/2021.  , ODD, and Generalized  ed 07/26/2021 specified, ocus Behavioral Health [FC#8] had been charged atory sexual offense for inappropriate behaviors with se of 911. [FC#8]  ne after being placed on Registry at the age of 15."	V 109			
	·	ed 19 while at the facility, I months after the end of the				
	surveyors due to his of a contract of the cont	with FC #8's parent lient would want to talk to experiences at the facility. FC #8) into buying a car ter for \$3,000 - a 2006  numerous problems with and the FC#8's mother had FC #8) a car - a 1995				

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 6 of 79

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	=1ED
			D WING			
		MHL012-137	D. WING		10/0	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PARK PLA	ACE	109 PARK	ER LANE			
		MORGAN	TON, NC 2865	5		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 109	Continued From page	e 6	V 109			
V 109	Chevrolet CavalierAfter FC #8's got his forth from the facility -As far as he (FC #8's allowed to assist him getting his license).  Interview on 09/21/20 -She was responsible implementing and up plans goals and strate. She wasn't at the face (06/02/2021) happen -"Kids didn't say anyt later." -FC #7 remained at the reported the incident"We had to keep eye all times. We didn't has [Managed Care Orga would give us one. I client (FC #7) at all tim make sure someone -Held meeting on 06/decided it was best to hospital"He [FC #6] said he he went back to the fashe (the QP) and the placement for FC #7 incidentSent out numerous rone would take him of -Department of Social	license, he drove back and to work all the time. Is parent) knew staff was in learning to drive (prior to all 21 with the QP revealed: It for developing, dating all client treatment egies. Easility when the incident ed. It hing until a couple of days the facility after FC #6  The so on that client (FC #7) at ave a 1:1 staff and inization-MCO] said they had to keep eyes on this mes because I wanted to was watching him (FC #7)."  109/2021 for FC #6. Team to have him admitted to the would hurt that kid [FC #7] if acility."  11 erapist attempted to locate prior to the 06/02/2021  12 efferrals for FC #7 and no lue to his behaviors. Il Services (DSS) was initially arge notice for FC #6 on	V 109			
	-After the 06/02/2021	ਸ਼ਟਗ਼ਾਲ. incident, "[the facility's Program Director] told them				
	they [DSS] were just	going to have to come and The discharge notice got				

Division of Health Service Regulation

STATE FORM 6899 NBPP11 If continuation sheet 7 of 79

Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		MHL012-137	B. WING		10/0	5/2021
		WINL012-137			10/0	15/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STA	TE, ZIP CODE		
		109 PARI	(ER LANE			
PARK PLA	ACE .		ITON, NC 2865	5		
	CUMMADVCT		<u> </u>		\1	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
V/ 100	O " 15	-	V 109			
V 109	Continued From page	<del>;</del> /	V 109			
	extended to June 30t	h."				
	-Staffing ratio for the					
		day we don't have two staff -				
		one staff - one staff is the				
		have two most of the time."				
	=	sexualized comments "all				
	the time" but he wasr					
		admitted clients from their				
	, ,,					
	Level III programs (Offense Specific (OS)) where sexualized behaviors were already in the					
		she (the QP) would update		Staff ratio will always be at least 1 st	taff for	
	the treatment plans a			every 4 kids, 24 hours a day, 7 days		10/28/2021
		lidn't come from an OS		week.	a	10,20,202
		not in the plan. I see your		Wook.		
		added that for [FC #7]."		Counseled with the QP that goals m	ust be	
	_	nain goals were for life skills		updated and reviewed to ensure tha		10/27/2021
	to be developed".			pressing behaviors are identified and		10,2
		rs old while at the facility.		on.	-	
		illity could take clients up to				
	age 21.			Agency did have an oversight on		
		ay through Friday and had a		requesting a waiver for FC#8; the ag	gency	
	car.			should have submitted the appropria		
		a car that did not run.		paperwork to DHSR if a similar situa	ition	
		local tire shop which was		arises.		
	where he worked.					
		t ran - "So, we got a car that				
	ran."					
		C #8 her grand-daughter had				
		(FC #8) asked to look at it.				
		ed her grand-daughter's car.				
		n the car to get gas; FC #8				
		a licensed driver at the time				
	as he only had his pe	rmit.				
	This deficiency is cros	ss referenced into 10A				
	NCAC 27G.1301 Sco	ppe (V179) for a Type A1 rule				
	violation and must be	corrected within 23 days.				
			1			

Division of Health Service Regulation

STATE FORM 6899 NBPP11 If continuation sheet 8 of 79

Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL012-137	B. WING	B. WING		5/2021
NAME OF PLA	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	,	
I AIXIX I EA	10L	MORGAN	TON, NC 28655	5		
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 110	Continued From page	8	V 110			
V 110	27G .0204 Training/Supervision Paraprofessionals		V 110			
	SUPERVISION OF P  (a) There shall be not paraprofessionals.  (b) Paraprofessional associate professional associate professional professional associate professional associate professional associate professionals knowledge, skills and population served.  (d) At such time as a employment system in the qualified professionals shall defend the professional shall shall be professional associate professionals associate p	fied in Rule .0104 of this s shall demonstrate abilities required by the  competency-based s established by rulemaking, cionals and associate emonstrate competence. Il be demonstrated by ncluding: dge; ss;  fills; skills; and dy for each facility shall ent policies and procedures individualized supervision in paraprofessional.				

Division of Health Service Regulation

Based on record reviews, and interviews, the

STATE FORM 6899 NBPP11 If continuation sheet 9 of 79

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND FLAN	JF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		COMPL	ETED
		MIII 040 407	B WING		40%	NE (0004
		MHL012-137	1 5: *******		10/0	05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
PARK PLA	ACE	109 PARKE		_		
		MORGANT	TON, NC 2865	5		1
(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 110	Continued From page	= 9	V 110			
	facility failed to ensur demonstrated knowle the population served #2, #3, and #4) audite Review on 09/15/202 record revealed: -Hire date of 06/15/20 - Employed as a Res-Documentation of counties the following areas; S Training-07/10/2020 a Supervision-05/05/20 -Job description signed specified,"maintain with the clients at all funderground communications.	re paraprofessionals edge, skills and abiliites for d for 4 of 4 Staff (Staff #1, ed. The findings are: 21 of Staff #1's personnel 020. idential Milieu Counselor. ompleted trainings included Specific Population and Informed 020. ed by Staff #1 on 06/15/2020 of a direct line of supervision times to prevent nication, physical, sexual, or happening. Monitor clients		Staff will immediately reach out to their sure or on-call staff when direct care staff do not up or identify that they will be late for their Supervisor or on-call staff will immediately replacement and fill in at the group home arrives. If staff shortages continue (due to then the senior management will consider changing the home to a 4 bed group home will hold QP accountable of requirements throughout the weekly meetings and QI and Program director will attend the upcoming meetings. During these meetings, exploits abuse and neglect will be reviewed with staff importance of identifying behaviors that to be addressed on and being aware of a PCP including goals. QI and Program Dirreview the needs of ensuring staff provide adequate notice when they are calling in shift. Will review with direct care staff the they need to meet their goals - i.e. line of (supervision of clients), calling immediate staff doesn't come into work.	ot show r shift. y find a until one o COVID) r le. We and g monthly ation, staff and lat need client's ector will be for their needs sight	10/05/2021
	record revealed: -Hire date of 03/17/20 -Employed as a Residual Documentation of control the following areas; Sound informed Supervulob description signs specified, "assist primproving their behave treatment goals in ord Staff members are rounded enough the served goals. Maintain a direction of sight of clients of sight of clients for the served goals. Maintain a direction of sight of clients for sight of clients"	dential Milieu Counselor. completed trainings included Sexual Behaviors in Children ision 08/02/2006. ed by Staff #2 on 08/16/2017 copulation served in viors and meeting their der to become independent. ble models and actively d to meet overall behavior ect line of supervision with				

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 10 of 79

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED	
				B. WING		
		MHL012-137	B. WING		10	0/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
PARK PL	ACE		RKER LANE			
	T		NTON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 110	-"[Staff #2], it was ide were not in the hallw there is more than 1 footage around 4:25 -Additional disciplinal provide group superv 2/23/2021, 04/20/2020 06/16/2021.  Review on 09/27/202 record revealed: -Hire date of 06/15/2 -Employed as a Resi -Job description sign specified," assist proving their behave treatment goals in or Staff members are reengage clients serve	entified on June 2 that you ay monitoring clients when as seen on video camera pm".  ry notices for failure to vision to clients on; 21, 05/25/2021, and  21 of Staff #3's personnel  018.  dential Milieu Counselor. ed by Staff #3 on 06/15/2018 population served in viors and meeting their der to become independent. ple models and actively d to meet overall behavior ect line of supervision with	V 110			
	line of sight of clients supervision as requir and Procedures 7-00 -"[Staff #3], it was ide were not in the hallw there is more than 1 footage around 4:25 -Additional disciplina provide supervision a 03/31/2020, 06/30/20 04/20/2021, and 05/2 Review on 09/27/202 record revealed: -Hire date of 02/04/2 -Employed as a Resi	entified on June 2 that you ay monitoring clients when as seen on video camera pm".  ry notices for failure to and group supervision on; 020, 02/23/2021, 03/16/2021, 25/2021.				

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 11 of 79

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING			
		MHL012-137	B. WING		10/05/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PARK PLA	ACE	109 PARK				
		MORGAN	TON, NC 28655	5		
(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 COMPLETE	
V 110	Continued From page	e 11	V 110			
V 110	the following area; Of and Sexual Behaviors -Job description signs specified," assist primproving their behave treatment goals in ord Staff members are rounded entered entered goals. Maintain a direction of the clients"  -Offense Specific Pop Behaviors Training-Offense Specific	iffense Specific Populations is Training-01/12/2007. The proposition of the served in th	V 110			
	-Clients must be mon unsupervised. -"One client can go of	,				

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 12 of 79

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	
		MHL012-137	B. WING		10/0	5/2021
NAME OF P	ROVIDER OR SUPPLIER	109 PARKE	RESS, CITY, STA			
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 110	complete chores inside monitoring Client #2 (window.  -"He (Client #2) was to outside, but it ended to walk off."  -Noticed Client #2 waline of sight, informed and then went to look vehicle.  -Found Client#2 playing bottom of the street.  Interview on 09/27/20.  -The level of supervision the clients in our site.  -She was on duty dur.  -Arrived at 11 am and picnic table outside.  -Checked on him eve.  -Last check he was g.  -Called the Qualified informed to call 911.  -Staff #1 went to look van.  -Client #2 was missing minutes when Staff #4 back to the facility.  -She was no longer a employee with the ag (09/12/2021).  Review on 09/22/202 09/12/2021 incident re-Staff #4 called 911 a	as monitoring other clients le the facility and also who was outside) through a aking a 5-10 minute timeout up being an hour. I saw him s no longer in his (Staff #1) his co-worker (Staff #4) for Client #2 in the facility's ng in the creek at the  21 with Staff #4 revealed: ion expectation was to have at all times. ing the 09/12/2021 incident. Client #2 was seated at  ry 2-3 minutes. one. Professional (QP) and was for Client #2 in the facility's g for approximately 20 1 found and brought him n as needed (PRN) ency as of 2 Sunday's ago  1 of the 911 recording of evealed:	V 110			

Division of Health Service Regulation

STATE FORM 6899 NBPP11 If continuation sheet 13 of 79

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL012-137	B. WING		10/0	05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PARK PLA	ACE	109 PARKE				
	OLIMAN DV OT		ON, NC 28655			
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 110	Continued From page 13		V 110			
	-Clients must be mon-Staff did a head cour clients are within their -"With these 5 boys the only 1 staff. Saturday for few hours with no-Denied being aware occurrences between incident report on 06/Interview on 09/23/20-She was on duty dur-"I was in the bathroo expectation was for the on clients when I was was the staff that was that and it will not hap #2) was probably in the and I usually sit right.  This deficiency is cross NCAC 27G.1301 Scott	nt every 5 minutes to ensure r view. here are times when it is and Sunday; 1 staff is left other staff." of any attempted sexual clients. However, per 02/2021 she was on shift.  121 with Staff #3 revealed: ing the 06/02/2021 incident. m when that happened. The ne other staff to keep eyes in the bathroom. [Staff #2] is there. I got reprimanded for open again. I think she (Staff he med (medication) room				
V 112	27G .0205 (C-D) Assessment/Treatme	nt/Habilitation Plan	V 112			
	PLAN (c) The plan shall be assessment, and in p legally responsible per of admission for clien receive services beyond) The plan shall income.	developed based on the artnership with the client or erson or both, within 30 days ts who are expected to and 30 days. Elude:		Staff will provide the client with a 30 day discharge notice and then apply for a warextend the client's stay in the program was placement is problematic. This waiver was provided to the respective MCO and DH	aiver to hen ill be	10/05/2021

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 14 of 79

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		MHL012-137	B. WING		10	/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
PARK PLA	ACE		KER LANE			
	·	MORGA	NTON, NC 28655			
(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 T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 112	projected date of ach (2) strategies; (3) staff responsible (4) a schedule for re annually in consultati responsible person o (5) basis for evaluat outcome achievemen (6) written consent or	ievement; ; eview of the plan at least on with the client or legally r both; ion or assessment of	V 112			
	facility failed to devel strategies to meet the clients audited (Clien Clients (FC) audited are:  Review on 09/16/202 #2's record revealed: -Admission date of 7/2-Age 16 yearsDiagnoses of Bipola Disorder, Personal ha	ews and interviews the op and implement goals and e needs for 1 of 2 current t #2) and 2 of 3 Former (#6 and #7). The findings				

Division of Health Service Regulation

STATE FORM 6899 NBPP11 If continuation sheet 15 of 79

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 BOILBING.			
		MHL012-137	B. WING		10/05/2	021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
PARK PLA	ACE	109 PARKI		_		
			TON, NC 28655			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE C	(X5) COMPLETE DATE
V 112	Continued From page	÷ 15	V 112			
V 1112	include the following: 9 year old neighbor a watching child pornog masturbation, using n running down the stre particpated in oral se: location and made a rubbing the nipples of pornography (includir getting on porn at sch  Interview on 9/15/21  -One of Client #2's per room smelled.  -When he inspected, urinated in 3 different -This continued to be -One client can go ou must remain in his lin -On 9/12/21 he was n complete chores insid monitoring Client #2 ( window.  -"He (Client #2) was to outside, but it ended to walk off."  -Noticed Client #2 wa line of sight, informed and then went to look vehicleFound Client #2 play bottom of the street.	left a note on the door for a sking to have sex, history of graphy, excessive nother's sex toys in anus, set in his underwear, it with male peers at current colan to rape an individual, in an animal, draws and babies and toddlers), and nool."  with Staff #1 revealed: wers let him know the clients the noticed Client #2 had places in his room. a problem for Client #2. tside alone, but the client to e of sight at all times. In nonitoring other clients' the the facility and also who was outside) through a making a 5-10 minute timeout tup being an hour. I saw him to so no longer in his (Staff #1) his co-worker (Staff #4) I Client #2 in the company ting in the creek at the with Staff #2 revealed:	V 112			
	of his roomhe would walk outsic -he walked up and do					
	-usually she would me in and he would.	otion for him to come back				

Division of Health Service Regulation

STATE FORM 6899 NBPP11 If continuation sheet 16 of 79

Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MI II TIDI E	CONSTRUCTION	(X3) DATE SURV	EV	
	OF CORRECTION	IDENTIFICATION NUMBER:				COMPLETED	
			A. BUILDING: _				
			D MINO	D 14/110			
		MHL012-137	B. WING		10/05/20	021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
		109 PAR	ER LANE				
PARK PLA	ACE.		TON, NC 2865	5			
	CUMMADV CT		<del></del>		N.	0.45)	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) OMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI	RIATE	DATE	
				DEFICIENCY)			
V 112	Continued From page	- 16	V 112				
	Continued From page	3 10					
		021 with Staff #4 revealed:					
	1	ring the 09/12/2021 incident.					
		l Client #2 was seated at					
	picnic table outside.						
	-Checked on him eve	-					
	-Last check he was g						
		Professional (QP) and was					
	informed to call 911.						
	-Staff #1 went to look	for Client #2 in the					
	company van.						
		g for approximately 20					
		1 found and brought him					
	back to the facility.						
	_	n employee with the agency					
	as of 2 Sunday's ago	(09/12/2021).					
	D : 00/00/000	4 511 044 1: 5					
		1 of the 911 recording of					
	09/12/2021 incident r						
	-Staff #4 called 911 a	- · ·					
		#2 had been missing for an					
	hour.						
	Interview on 9/21/21	with Client #2's					
	parent/quardian revea						
	'	l of supervision was that					
		e two staff on duty and eyes					
	would be on them at	-					
		e time the client left the					
	facility property witho						
		eeks ago, Sunday, staff					
	called and said he wa						
	driveway.						
		e staff never lost sight of the					
		sure staff followed him to					
	where he was going.	Tan I show a finite					
		e police were called or not.					
		hat the client was at the end					
		and gone for almost an hour.					
		ne Qualified Professional					

Division of Health Service Regulation

STATE FORM 6899 NBPP11 If continuation sheet 17 of 79

Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		LETED	
		MHL012-137	B. WING		10/	05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	ΓΕ, ZIP CODE		
			KER LANE	,		
PARK PLA	ACE		ITON, NC 28655			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION ( CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETE DATE
V 112	Continued From page	e 17	V 112			
	on the bed and on his -This was a known be in their FOCUS Level -Him urinating in inap to cover up when he	ehavior when the client was III program. propriate places was a way masturbated. Level III the staff allocated				
	7/15/21 revealed: -"[Client #2] struggles and not expressing hi way." -"[Client #2] continues boundaries with is pe struggles with building under goal #2 - " Z inappropriate behavior engaging in sexually	Client #2's file (PCP) last updated s with arguing with others is feelings in an appropriate s to struggle with appropriate ers as well as staff and g appropriate relationships." ero incidents of sexually ors (viewing porn, grooming, explicit conversations, execual manner, allowing				
	other to touch him se or buttocks to others, activity with children, others, etc)." -"[Client #2] struggles hygiene and keeping clean, and free of clui socializing with others out in the community society." -there were no strated the client urinating in	engaging in any sexual or masturbating in front of with maintaining proper his surroundings neat, tterneeds help with and reacclimating to being as a productive member of gies to specifically address inappropriate places to g, and none to address him ssion/supervision.				

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 18 of 79

Division of Health Service Regulation

Division of Health Service Regulation		
	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING:	COMPLETED	
MHL012-137 B. WING	10/05/2021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
PARK PLACE		
MORGANTON, NC 28655		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETE	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATION		
DEFICIENCY)		
V 112 Continued From page 18 V 112		
John Pago 10		
-Age 16 years.		
-Diagnoses of Attention Deficit Hyperactive		
Disorder (ADHD), Persistent Depressive Disorder		
(dysthymia disorder), Oppositional Defiant		
Disorder (ODD)-Adolescent-onset type Conduct Disorder.		
-Comprehensive Clinical Assessment (CCA)		
addendum dated 04/07/2021 specified;		
"Previously recommended transitioning to an		
interim level II therapeutic foster home however		
this placement fell through and client's verbal		
aggression and inappropriate behaviors have only		
escalated. As such, client is being referred to a		
level III placed based on the following criteria:		
client's identified needs cannot be met d/t (due to)		
client experiencing frequent and severe conflict in		
the setting, consistently demonstrates defiance		
and verbal aggression calling staff and peers		
vulgar names; makes threat and false		
accusations; verbal aggression, defiance and		
disrespect, physically posturing and blocking staff		
to get what and where he wants will not follow		
prompts or redirection the current group home primarily consists of setting for adolescent males		
with problem sexualized behaviors (PSBs) after		
they have successfully completed the PSB		
program. Client very aware of this yet continues		
to make graphic sexualized comments and		
physical gestures that would be characterized as		
sexual harassment. Shows no remorse for his		
actions and never apologizes. Client laughs at his		
sexualized behaviors."		
Review on 9/17/21 of a document entitled "This is		
a summary of [FC #7's] comments and concerns		
from March 16th - June 29th, 2021" included:		
-"[FC #7] makes sexual comments and gestures		
that appeared to make his peers feel unsafe and		

Division of Health Service Regulation

-"He told a peer that he wanted his oily hands on

STATE FORM 6899 NBPP11 If continuation sheet 19 of 79

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL012-137	B. WING		10/05/2024
				T. 710 0005	10/05/2021
NAME OF P	ROVIDER OR SUPPLIER		ODRESS, CITY, STAT	E, ZIP CODE	
PARK PLA	ACE		KER LANE NTON, NC 28655		
0/0.15	SLIMMADV ST.	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORREC	TION
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETE
V 112	Continued From page	<del>2</del> 19	V 112		
V 112	his body and said, "I I twice. Said 'Umm'! (at out of the bathroom a shaving)."  -"Told staff and peersthat he needs 8 incl -"Had saran wrap in h front of peers that it w -"Several times he tal sticking things in his r -"He said he was goir "head" in the bathrood -"He asked staff and a fellatio was and if the asked a peer again the and proceeded to use meaning of the word know what [FC #6] m -"Made comments ab likes and said, I want good." -"Warning staff to kee because if he was ald would grab that peer's would grab that peer we sexual statements the reference to his "crus -"Telling another peer the peer's butt and the noted that [FC #7] ap around and stand too -"[FC #7] sings a lot of staff and peersmak and dance moves. To make it look like he is straddling the back of horseblowing kisses.	ike a man with oily hands" fiter that same peer came fiter showering and  what he likes put in his butt hes." his book bag and told staff in vas his homemade condom." ked about anal sex and fear." hig to give a classmate m at school" a peer if they knew what y had ever done that. He hat evening if he liked fellatio a gestures to explain the when the peer said he didn't feant." out what sexual positions he some d**k. D**k tastes  Ap a close eye on him he with a certain peer, he so butt. It is noted that [FC he basketball court on a chair while making inappropriate at staff could hear in h."  What he would like to do to hen saying, 'Umm'. It is heared to follow this peer closely to the peer" of inappropriate lyrics around tes inappropriate gestures werking, hiking shorts up to conly wearing a t-shirt, if the couch as if he is on a hes at staff, licking his feet,			
		a sexual mannerand			

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 20 of 79

Division of Health Service Regulation

	OF DEFICIENCIES					
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		ETED
		MHL012-137	B. WING		10/0	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
		109 PARI	KER LANE			
PARK PLA	ACE.		TON, NC 28655	5		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETE DATE
V 112	Continued From page	e 20	V 112			
	bounced around his p	peers and staff "				
		havioral one staff had to				
		b keep him and his peers				
	safe"	o neep mm and me peers				
	Review on 09/14/202	1 and 09/23/2021 of the				
	facility incident report	s from 06/01/2021 to				
	09/14/2021 revealed:					
	-Incident report submitted 06/08/2021 for 06/02/2021 incident regarding Former Clients (FC) #6 and #7: -"Client was approached by a peer [FC #7] who					
		down and repeatedly asked				
	for the client to allow	•				
	fellatio."	to give and enem				
	D i 0/40/04 f	: FO #71- DOD 1+ 1-+- 1				
		FC #7's PCP last updated iew dates of 5/18/21 and				
	6/23/21 with goal revi	lew dates of 5/16/21 and				
		ith accepting redirection and				
		o find it difficult to follow				
	program expectations					
		21 - client not checking his				
	1	ing inappropriate sexual				
	comments, gestures	and dancing in a provocative				
	manner.					
		21 - client making sexual				
		hree peers complained of				
		client refers to another peer out wanting a man, what he				
		do to him, and what he				
	wanted to do to other					
		struggle with not thinking of				
		d remarks about others, and				
	a lack of empathy tow	vards his staff and peers on				
	_	work on building positive				
	-	ability to make more positive				
	decisions.					
		ntinue learning life skills that				
	will help him live inde	penaentiy."				

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 21 of 79

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7.1.2 . 27.1.1		A. BUILDING:			33 22.125
		MHL012-137	B. WING		10/05/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
PARK PLA	ACE	109 PARK	ER LANE		
.,		MORGAN	TON, NC 28655	5	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
V 112	Continued From page	e 21	V 112		
	-There was no specifi	ic goal addressing the havior or strategies to curtail			
	revealed: -Admission date of 02	0/28/2020			
	-Age 19 years.	2/20/2020.			
	-Diagnoses of ADHD, ODD, and Generalized Anxiety DisorderCCA addendum dated 07/26/2021 specified,				
	"Prior to coming to Fo				
		[FC#8] had been charged tory sexual offense for			
	engaging in sexually his siblings and misus	inappropriate behaviors with			
		ne after being placed on			
		esult, [FC#8] was placed on Registry at the age of 15."			
	Review on 09/16/2021 of FC #8's Person-Centered Profile dated 02/02/2021 revealed: -"[FC #8] struggles with acting in an immature manner and admits that he needs help managing				
		b balance wants and needs			
	his daily life AEB [as	ills and apply these skills in evidenced by]: balancing			
	money, writing check -How (Support/Interve	ention): to participate in			
		pack and alter ways of nonest, contact licensee in			
	situations of escalatination attend Child and Fam	ng or in emergencies, and nilly Team meetings.			
	-There were no speci the client will manage	fic strategies to indicate how his money.			

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 22 of 79

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED	
			B. WING				
		MHL012-137	D. WING		10/0	05/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
PARK PLA	<b>ACE</b>	109 PARK	ER LANE				
		MORGAN	TON, NC 2865	5			
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
V 112	Continued From page	e 22	V 112				
	Monday-Friday, unsuland was driven to and until FC #8 obtained Interverse of supervision of measures while at woodfender Registry states. Interview on 9/21/21 grevealed:  -He did not feel the obsurveyors due to his ended and aughter for \$3 Galant.  -FC #8 had numerous -FC #8's parents had 1995 Chevrolet Cavar -After the client got his forth from the facility states.	ific strategies to address or community safety ork given FC #8 's NC Sex situs.  with FC #8's parent/guardian lient would want to talk to experiences at the facility. If it is into buying a car from her 1,000 - a 2006 Mitsubishi or problems with that car. It is already bought him a car - a lier- he did not need a car. It is license he drove back and					
	-She was the QP for	with the QP revealed: the facility and responsible nt and update treatment plan					
	-Client #2 left the pre the creek down the ro	mises (9/12/21) and went to pad.					
	the police.	searching for him staff called					
		ne Client #2 left the property.  Alk down the driveway and sit					
	-She talked with Clier therapist after this inc						
	<ul> <li>They agreed if the cl step outside and sit of</li> </ul>	lient was upset, he could on the picnic table.					

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 23 of 79

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	COMPI		(X3) DATE SU	
7.1.12 . 27.11 .						
		MHL012-137	B. WING		10/05	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
PARK PLA	ACE.	109 PAR	(ER LANE			
PARK PLA	NOE	MORGAN	ITON, NC 28655	5		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 112	V 112 Continued From page 23		V 112			
V 112	-Staff were to check coutside; one time he check he was gone (rincident)Now that they know have to keep eyes on This was not added tigust talked about additigust talked about added talked about additigust talked about a	on him when he went was there and the next referring to the above the goes outside the staff will him at all times. To the treatment plan as they right monday (9/20/21). The extraction of them. The extraction of the extraction of the extraction of them. The extraction of the extraction o	V 112			
	-Staff went with FC #8 #8 could only drive wi time as he only had h This deficiency is cros	B in the car to get gas; FC ith a licensed driver at the				

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 24 of 79

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		IED
		MHL012-137	B. WING		10/05	5/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
PARK PLA	ACE	109 PARK	ER LANE			
.,		MORGAN	TON, NC 2865	5		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 112	Continued From page	e 24	V 112			
	violation and must be	corrected within 23 days.				
V 179	27G .1301 Residentia	al Tx - Scope	V 179			
	10A NCAC 27G .130					
	(a) The rules of this stresidential treatment	Section apply only to a				
		level II, program type				
	service.	hanna a tha nilite e a ann ei dian a				
	(b) A residential treatment facility providing residential treatment, level III service, shall be					
	licensed as set forth i	n 10A NCAC 27G .1700.				
		ment facility for children and standing residential facility				
		ctured living environment				
	within a system of car	re approach for children or				
		e a primary diagnosis of tional disturbance and who				
	may also have other					
		designed to address the				
	-	e child or adolescent and f-control, communication				
	skills, social skills, an	d recreational skills.				
		nts may receive services in a have a job placement, or				
	attend school.	mave a job placement, or				
		designed to support the				
		gaining the skills necessary al, or therapeutic home				
	setting.	·				
	(f) The residential tre	eatment facility shall individuals and agencies				
	within the client's syst					
	•					

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 25 of 79

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL012-137	B. WING		10/05/2021
			DDDEGG OFFICE		10/00/2021
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE	
PARK PL	ACE		KER LANE NTON, NC 2865	55	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 179	Continued From page	e 25	V 179	,	
	facility failed to opera program which is to p environment within a adolescents who hav illness, emotional dist affecting five of five c and #5) and 3 of 3 Fo (#6, #7 and #8). The CROSS REFERENC Competencies of Qua Associate Profession	ews and interviews, the te within the scope of their provide a structured living system of care approach for e diagnoses of mental turbance or other disabilities, lients (Clients #1, #2, #3, #4 prmer Clients (FC) audited findings are:  E: 10A NCAC 27G .0203 alified Professionals and als (V109).Based on record vs, 1 of 1 audited Qualified		Program & QI Director attended monthly meeting on 10/26 and discussed the staff importance of ensuring that clients who meeting struggles between each other that pose a and/or unsafe behaviors need to be monimore closely. Focus BHS will update the better reflect the type of setting and structure Residential Level II group home should encompass. The update in policy and job descriptions will be reviewed by staff durin November's staff meeting.  Client's who approach their 18th birthday BHS staff will acquire a waiver.	f of the hay have risky tored policy to ture a 10/26/2021
	knowledge, skills and population served.  CROSS REFERENC Competencies and Si Paraprofessionals (V reviews, and interviewensure paraprofessionals)	abilities required by the  E: 10A NCAC 27G .0204 upervision of 110). Based on record ws, the facility failed to nals demonstrated opulation served for 4 of 4			
	CROSS REFERENC Assessment and Trea Service Plan (V112). and interviews the fac and strategies to mee current clients audited Former Clients (FC) a	E: 10A NCAC 27G .0205 atment/Habilitation or Based on record reviews cility failed to develop goals et the needs for 1 of 2 d (Client #2) and 2 of 3			
	Staff (V180). Based o				

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 26 of 79

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		MHL012-137	B. WING		10	0/05/2021
	PROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
PARK PL	ACE		NTON, NC 28655			
(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 ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 179	times at least one dire with every four childre five of five clients (Cli CROSS REFERENC Operations (V182). B interviews, the facility the age limitations for affecting 1 of 3 Forms CROSS REFERENC Incident Response Re and B Providers (V36 and interviews, the fawritten policies gover and level III incidents CROSS REFERENC Incident Reporting Re and B Providers (V36 record review, the fact Level II and III incident Management Entity (I where services are proposed becoming aware of the CROSS REFERENC Client's Personal Function of the CROSS REFERENC Client's Personal Functio	ect care staff was present en or adolescents affecting ents #1, #2, #3, #4 and #5).  E: 10A NCAC 27G. 1303 ased on record reviews and failed to assure clients met clients in a 1300 facility er Clients (FC) audited (#8).  E: 10A NCAC 27G.0603 equirements for Category A 66). Based on record reviews cility failed to implement ning their response to level II  E: 10A NCAC 27G.0604 equirements for Category A 67). Based on interview and cility failed to ensure that all hats be reported to the Local LME) for the catchment area rovided within 72 hours of the incident.  E: 10A NCAC 27F.0105 dos (V542). Based on record vs., the facility failed to assist a Former Clients (FC) ain and invest personal fund account.  1 of the Plan of Protection and invest personal fund account.  1 of the Plan of Protection and invest personal fund account.  1 of the Plan of Protection and invest personal fund account.  1 of the Plan of Protection accion will the facility take to the consumers in your care?  1.0203 (V109): Competencies	V 179			

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 27 of 79

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7.1.2 / 2.07 67 667.0.267.167.		A. BUILDING:		"	
	MHL012-137	B. WING		10/0	5/2021
NAME OF PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	ATE, ZIP CODE		
	109 PARK	ER LANE			
PARK PLACE	MORGAN <sup>-</sup>	TON, NC 2865	5		
PREFIX (EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY 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
qualified professional (b) Qualified professionals shall dand abilities required (c) At such time as a employment system then qualified profess professionals shall d (d) Competence shaexhibiting core skills (1) technical knowled (2) cultural awarened (3) analytical skills; (4) decision-making; (5) interpersonal skill (6) communication s (7) clinical skills. (e) Qualified profess NCAC 27G .0104 (1 met the requirement employment system MH/DD/SAS. (f) The governing bodevelop and implem for the initiation of ar plan upon hiring eac (g) The associate prosupervised by a qualified in Rule .01 CORRECTION: Cascomplete a retraining immediately; this professional shall be systaff and not iden	o privileging requirements for als or associate professionals. Sionals and associate demonstrate knowledge, skills of by the population served. As competency-based is established by rulemaking, sionals and associate demonstrate competence. The demonstrate demonstrate demonstrated by including: dge; sss;  Sills; skills; and demonstrated in 10 A 8)(a) are deemed to have so of the competency-based in the State Plan for dy for each facility shall ent policies and procedures in individualized supervision the associate professional.	V 179	Case responsible QP completed a retrof PCP guidelines and rules immediate process will be completed with either t Program, Clinical and/or QI Director; reoccurring client behaviors that are addressed by staff and not identified a need in the PCP warrants for goals to changed, revised and/or added."	ely; this he s a	10/27/2021

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 28 of 79

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S	
			A. BUILDING:	A. BUILDING:		
		MHL012-137	B. WING		10/0	5/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DADIC DI A		109 PARKE	ER LANE			
PARK PLA	ACE	MORGANT	ON, NC 2865	5		
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 179	Continued From page	28	V 179			
V 179	and Supervision of Pa (a) There shall be no paraprofessionals. (b) Paraprofessionals associate professional professional as specifications subchapter. (c) Paraprofessionals knowledge, skills and population served. (d) At such time as a employment system i then qualified profess professionals shall de (e) Competence shall exhibiting core skills i (1) technical knowled (2) cultural awareness (3) analytical skills; (4) decision-making; (5) interpersonal skills	anaprofessionals privileging requirements for  shall be supervised by an all or by a qualified fied in Rule .0104 of this  shall demonstrate abilities required by the  competency-based sestablished by rulemaking, ionals and associate emonstrate competence.  be demonstrated by including: ge; s;	V 179			
	develop and impleme for the initiation of the plan upon hiring each CORRECTION: Staff to their supervisor or care staff do not show be late for their shift. will immediately find a the group home until -"(C) 10A NCAC 27G Assessment and Treaservice Plan (c) The plan shall be assessment and in page 100 plan with the plan shall be assessment and in page 100 plan with the plan shall be assessment and in page 100 plan with the plan shall be assessment and in page 100 plan with the plan shall be assessment and in page 100 plan with the plan shall be assessment and in page 100 plan with the plan shall be assessment and in page 100 plan with the plan shall be assessment and in page 100 plan with the plan shall be assessment and in page 100 plan with the plan shall be assessment and in page 100 plan with the plan shall be assessment and in page 100 plan with the plan shall be assessment and in page 100 plan with the plan shall be assessment and in page 100 plan with the plan shall be assessment and in page 100 plan with the plan shall be assessment and in page 100 plan with the plan shall be assessment and in page 100 plan with the plan shall be assessment and in page 100 plan with the plan shall be assessment and in page 100 plan with the plan shall be assessment and the pla	ly for each facility shall int policies and procedures individualized supervision paraprofessional. will immediately reach out on-call staff when direct v up or identify that they will Supervisor or on-call staff a replacement and fill in at one arrives."		Staff will immediately reach out to thei supervisor or on-call staff when direct staff do not show up or identify that the late for their shift. Supervisor or on staff will immediately find a replaceme fill in at the group home until one arriv	care ey will -call ent and	10/26/2021

Division of Health Service Regulation

STATE FORM 6899 NBPP11 If continuation sheet 29 of 79

Division of Health Service Regulation

	or periornoise		(VO) MUUTIDU	CONCEDUCTION	(V2) DATE C	LIDVEV
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			A. BUILDING:			
		MHL012-137	B. WING		10/0	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	ATE, ZIP CODE		
		109 PARK		,		
PARK PLA	ACE		FON, NC 2865	<b>5</b>		
			TON, NC 2005	1		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	•	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
V 179	Continued From page	20	V 179			
V 179	Continued From page	29	V 179			
	of admission for clien	ts who are expected to				
	receive services beyo	ond 30 days.		0. 5 31 32 4 32 4 34 00 1		
	CORRECTION: Staff	will provide the client with a		Staff will provide the client with a 30 day d		
	30 day discharge noti	ice and then apply for a		notice and then apply for a waiver to exter client's stay in the program when placeme		10/05/2021
	waiver to extend the	client's stay in the program		problematic. This waiver will be provided to		
	when placement is pr	oblematic. This waiver will		respective MCO and DHSR.		
	be provided to the res	spective MCO and DHSR.				
	-"(D) 10A NCAC 27G	.1302 (V180): Staff				
	(a) Each facility shall	have a director who has a				
	minimum of two years	s' experience in child or				
	adolescent services a	and who has educational				
	preparation in admini	stration, education, social				
	work, nursing, psycho	ology or a related field.				
	(b) At all times, at lea	st one direct care staff				
	member shall be pres	sent with every four children				
	or adolescents. If chil	dren or adolescents are				
	cared for in separate	buildings, the ratios shall				
	apply to each building					
		e clients are in the facility, an				
		aff shall be readily available				
	by telephone or page	and able to reach the facility				
	within 30 minutes.			At all times, at least one direct care sta	aff	
		Itation shall be available as		member shall be present with every fo		
	needed for each clien			children or adolescents. If the ratio is 5		
	` '	on shall be provided by a		there shall be two staff available at all		
		h professional to each		If children or adolescents are cared for		
	facility at least twice a			separate buildings, the ratios shall app		
		l times, at least one direct		each building. Management - Lead QF		
		all be present with every		Director and Program Director will be i		
		scents. If the ratio is 5 or 6		immediately when there is a staff shor a staff no-show for their shift. This will		
		ff available at all times. If		appropriate staffing ratios are always	CHOULE	
		its are cared for in separate		maintained in keeping with the safety	of the	10/05/2021
		hall apply to each building.		clients being served. If coverage is no		
	Management - Lead			available, then one of the above menti		
	_	be notified immediately		management positions will be required		
		shortage or a staff no-show		cover until appropriate staffing ratios c		
		III ensure appropriate staffing		achieved. The goal is to have staff rat		
		ntained in keeping with the		at all times in keeping with agency pol	icy and	
		eing served. If coverage is		procedure and State and Federal regu	llations.	
	not available, then on	e of the above mentioned				

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 30 of 79

Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
		MHL012-137	B. WING		10/0	5/2021
NAME OF D		CTDEET AS	ADDECC CITY OF	ATE ZID CODE	<u></u>	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, ST.	ATE, ZIP CODE		
PARK PLA	ACE		(ER LANE	_		
		MORGAN	ITON, NC 2865	55		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
V 179	Continued From page	e 30	V 179			
	management position	ns will be required to cover				
		ing ratios can be achieved.				
		taff ratios met at all times in				
	•	policy and procedure and				
	State and Federal reg					
	-"(E) 10A NCAC 27G	.1303(d) (V182): Operations				
	(d) Age Limitation. If a	an adolescent has his 18th				
		ng treatment in a residential				
	•	nue in the facility for six				
		nd of the state fiscal year,				
		CORRECTION: In the future		In the future when an adolescent is		
		is approaching his 18th		approaching his 18th birthday Focus E		
	_	will notify the Managed Care		notify the Managed Care Entity for the		
		nd get approval for services		and get approval for services if the clic cannot be discharged by the 6 months		
		discharged by the 6 months		their 18th birthday or the end of the st		
		ay or the end of the state r is longer).   In addition, for		fiscal year (whichever is longer). In a		10/05/2021
	,	ng this issue a Waiver will be		for all future clients having this issue a		
		R so that the agency can		will be requested from DHSR so that t	he	
		itil appropriate placement		agency can maintain the client until		
		aivers will be completed on		appropriate placement can be obtained		
	an ongoing basis to e			Waivers will be completed on an ongo		
	approved to go outsic	de the limits of the statutory		basis to ensure the agency is approve outside the limits of the statutory	a to go	
	requirements."			requirements.		
		.0603 (V366): Incident		- squirement		
		ents for Category A and B				
	` '	ning a meeting of an internal				
		hours of the incident. The				
		shall consist of individuals				
		d in the incident and who				
	· ·	for the client's direct care or al oversight of the client's				
	=	of the incident. The internal				
		nplete all of the activities as				
	follows:	ripiete all of the activities as				
	(A) review the copy o	f the client record to				
		nd causes of the incident				
		dations for minimizing the				
	occurrence of future i					
	(B) gather other infor	•				

Division of Health Service Regulation

STATE FORM 6899 NBPP11 If continuation sheet 31 of 79

Division of	<u>of Health Service Regu</u>	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			-		
			B. WING		
		MHL012-137	B. WING		10/05/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, STA	TE, ZIP CODE	
		109 PAR	KER LANE		
PARK PLA	ACE		ITON, NC 2865	5	
0.40.15	CLIMMADY CT		<u> </u>		N 0.00
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	( -/
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	
				DEFICIENCY)	
V 179	Continued From page	. 21	V 179		
V 179	Continued From page	: 31	V 179		
	(C) issue written preli	minary findings of fact within			
	five working days of t	he incident. The preliminary			
	findings of fact shall b	e sent to the LME in whose			
	catchment area the p	rovider is located and to the			
	LME where the client	resides, if different; and			
	(D) issue a final writte	en report signed by the			
	owner within three mo	onths of the incident. The			
	final report shall be se	ent to the LME in whose			
	catchment area the p	rovider is located and to the			
	LME where the client	resides, if different. The			
	final written report sha	all address the issues			
	identified by the interr				
	include all public docu	uments pertinent to the			
	incident, and shall ma	ake recommendations for			
	minimizing the occurr	ence of future incidents. If			
	all documents needed	d for the report are not			
	available within three	months of the incident, the			
	LME may give the pro	ovider an extension of up to			
	three months to subm	nit the final report."			
	-"(G) 10A NCAC 27G	.0604 (V367): Incident			
	Reporting Requireme	nts for Category A and B			
	Providers. (a) Catego	ry A and B providers shall			
	report all level II incid	ents, except deaths, that			
	occur during the prov	ision of billable services or			
		on the providers premises			
		nd level II deaths involving			
		ne provider rendered any			
		s prior to the incident to the			
	•	he catchment area where			
	services are provided				
	_	e incident. The report shall			
	be submitted on a for				
		may be submitted via mail,			
		r encrypted electronic			
	·	all include the following			
	information:				
		contact and identification			
	information;				
	(2) client identification	n information:	1		

Division of Health Service Regulation

(3) type of incident;

STATE FORM 6899 NBPP11 If continuation sheet 32 of 79

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
			_			
		MHL012-137	B. WING		10	/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		109 PAR	KER LANE			
PARK PLACE MORGAN		NTON, NC 28655				
(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 ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 179	Continued From page	e 32	V 179			
	(4) description of incid	dont				
	(4) description of incide (5) status of the effort	t to determine the cause of				
	the incident; and	to determine the cause of				
	· ·	or authorities notified or				
	responding.	or durionado notinos di				
		providers shall explain any				
		e information. The provider				
	shall submit an updat	ed report to all required				
	report recipients by the	ne end of the next business				
	day whenever:					
	(1) the provider has reason to believe that					
	information provided					
		g or otherwise unreliable; or				
	· , ·	ns information required on was previously unavailable.				
		providers shall submit, upon				
		other information obtained				
	regarding the inciden					
	(1) hospital records in					
	information;	3				
	(2) reports by other a	uthorities; and				
	(3) the provider's resp	oonse to the incident.				
	(d) Category A and B	providers shall send a copy				
	of all level III incident	reports to the Division of				
	Mental Health, Devel	opmental Disabilities and				
		rvices within 72 hours of				
		ne incident. Category A				
	providers shall send a					
		client death to the Division of				
	_	ation within 72 hours of				
		ne incident. In cases of client ays of use of seclusion or				
		shall report the death				
		red by 10A NCAC 26C				
	.0300 and 10A NCAC					
		providers shall send a				
		LME responsible for the				
		e services are provided. The				
		tted on a form provided by				

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 33 of 79

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S	
			A. BUILDING:			
		MHL012-137	B. WING		10/0	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
DADK DI A	.05	109 PARKE	R LANE			
PARK PLA	ACE	MORGANT	ON, NC 2865	5		
(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 179	include summary info (1) medication errors definition of a level II (2) restrictive interver definition of a level II (3) searches of a client (4) seizures of client (5) the total number of incidents that occurre (6) a statement indicate reportable incidents who occurred during the quarteria as set forth in this Rule and Subpart this Paragraph.  CORRECTION: Per a and APSM 30-1 the arequirements as it relincidents. All Level II within 24 hours to the Program Director. The shall follow instruction appropriate entities, cobtaining client and swill the Lead QP wait report any incidents of Reporting requirements are reporting Level II incidents of Reporting the portion occurring during the portion of the LME rearea where services are of becoming aware of the commitments of the commitments of the LME rearea where services are of becoming aware of the commitments of the commitments of the commitments of the LME rearea where services are of becoming aware of the commitments o	ctronic means and shall rmation as follows: that do not meet the or level III incident; ations that do not meet the or level III incident; and or his living area; property or property in the t; of level II and level III and ating that there have been no whenever no incidents have uarter that meet any of the Paragraphs (a) and (d) of agraphs (1) through (4) of agency policy and procedure igency will follow all statutory ates to reporting of serious. I incidents must be reported at QI Director and NC in ergoram Manager - QP in sor reporting to conducting investigation, taff statements. At no time more than 24 hours to of a serious nature. Into shall follow 27G.0604 for dents, except deaths, that provision of billable services in son the providers within 90 days prior to the desponsible for the catchment are provided within 72 hours if the incident. If the lead is	V 179	Per agency policy and procedure and 30-1 the agency will follow all statutory requirements as it relates to reporting serious incidents. All Level III incident be reported within 24 hours to the QI I and NC Program Director. The Program Manager - QP shall follow instructions reporting to appropriate entities, conduinvestigation, obtaining client and staff statements. At no time will the Lead Comore than 24 hours to report any incide a serious nature. Reporting requirements shall follow 27G.0604 for reporting Levincidents, except deaths, that occurring the provision of billable services or who consumer is on the providers premises Level III incidents and level II deaths in the clients to whom the provider rendeservice within 90 days prior to the incidented LME responsible for the catchment where services are provided within 72 of becoming aware of the incident. If the is aware on day 1 then the lead WILL the report within 24 hours or immediated required entities. The investigative reports	of as must Director am for Jucting and Parish of Interest of Inter	10/05/2021
	•	the lead WILL make the		must all be completed according to ag and State and Federal requirements.		

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 34 of 79

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
		MHL012-137	B. WING		10/0	5/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
D4 D1 ( D1 )		109 PAR	ER LANE			
PARK PLA	ACE	MORGAN	TON, NC 2865	5		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
				DEFICIENCY)		
V 179	Continued From page	e 34	V 179			
	required entities. The	e investigative reports must				
		ording to agency and State				
	and Federal requirem					
	-"(H) 10A NCAC 27F.	.0105 (V542): Client's				
	Personal Funds					
	` ,	to any 24-hour facility which				
		idential services to individual				
	clients for more than					
		adult client and each minor				
	above the age of 16 s	ain or invest his money in a				
	•	nt other than at the facility.				
		t need not be limited to,				
		n interest-bearing accounts.				
		ged for a client by a facility				
	employee, managem	ent of the funds shall occur				
	Tel control of the co	olicy and procedures that:				
	• •	nt the right to deposit and				
	withdraw money;					
	, , -	pt and distribution of funds in				
	a personal fund acco					
	friends, relatives or o	ceipt of deposits made by				
		eping of adequate financial				
		ctions affecting funds on				
	deposit in personal fu					
		nt's personal funds will be				
	kept separate from a facility;	ny operating funds of the				
	-	duction from a personal fund				
		treatment or habilitation				
		ized by the client or legally				
	responsible person u					
	admission of the clier					
	(7) provide for the iss	uance of receipts to persons				
	depositing or withdra	•				
		with a quarterly accounting				
	of his personal fund a					
	(d) Authorization by t					
	responsible person is	required before a deduction				

Division of Health Service Regulation

STATE FORM 6899 NBPP11 If continuation sheet 35 of 79

Division of Health Service Regulation

DIVISION	n rieditii Service Negu	I				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		MHL012-137	B. WING		40/6	E/2024
		WINL012-137			1 10/0	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
DADK DI	10E	109 PAR	(ER LANE			
PARK PLA	ACE	MORGAN	ITON, NC 2865	5		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
V 179	Continued From page	e 35	V 179			
	can be made from a	personal fund account for				
		alleged to be owed for				
	_	eged to have been done by				
	the client:					
	<ol><li>(1) to the facility;</li></ol>					
	(2) an employee of th	•				
	(3) to a visitor of the f					
	(4) to another client of	•		This was addressed during the month	n of	
	CORRECTION: Ther			October with various supervisions. The		
		between any clients of		shall be no further financial transaction		
		f or their family. They shall		between any clients of Focus and dire	ect staff	
	_	shed Focus Policies around		or their family. They shall follow alrea	ady	
	management of clien			established Focus Policies around		
		taff in question upon their and personnel action shall		management of client funds. This sh		
		ther, when clients maintain		addressed with the staff in question u		
		accounts, staff shall do		their return from vacation and person action shall accompany that. Further		
	•	and follow the ADL Client		clients maintain jobs and have bank	, WIIEII	
	•	r ensuring they are able to		accounts, staff shall do financial cour	selina	
	manage their own fur			and follow the ADL Client Training ha		
	_	vithin the client's medical		for ensuring they are able to manage		40/00/0004
	•	ies have been addressed.		own funds. There will be documentat		10/28/2021
	Should a client have	difficulty in maintaining their		within the client's medical record that		
	finances and financia	I wellbeing then a financial		issues have been addressed. Should		
	trustee and/or guardia	an shall be established		have difficulty in maintaining their fina		
		manage those funds for		and financial wellbeing then a financial trustee and/or guardian shall be estal		
		w our agency policy around		within the agency to manage those fu		
		t funds and maintaining		them. We must follow our agency po		
	_	ial transactions. This may		around management of client funds a		
	be the Lead QP. The			maintaining records of any financial		
	supervision around th			transactions. This may be the Lead (		
	• •	ans to make sure the above		lead QP will receive supervision arou	nd	
	happensNo response indicate	ed		these issues.		
	-No response mulcate	5u.				
	Review on 10/05/202	1 of the Addendum to the				
		OP) dated and signed by the				
	North Carolina (NC) F					
	10/05/2021 revealed:					
	-(1) What Immediate	action will the facility take to				

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 36 of 79

Division of	of Health Service Regu	lation				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL012-137	B. WING		10/0	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE ZIP CODE		
TO THE OT T	NOVIDEN ON OUT LIEN	109 PARKI				
PARK PL	ACE		ON, NC 2865	5		
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 179	Continued From page	: 36	V 179			
	ensure the safety of the -(A) "10A NCAC 27G of Qualified Profession Professionals. CORR QP will complete a reand rules immediately completed with either and/or QI Director; transcription of Program and not identification warrants for goals to added. Lead QP will be neglect and abuse du with client buying the Weekly meetings will Program and QI Director addressed a procedures and be twenty of the will titrate concerns addressed a procedures and be twenty of the will be procedured and procedures and be twenty of the will immediately find a strength of the group home until shortages continue (of senior management whome to a 4 bed group Laurenda accountable throughout the weekly Program director will monthly meetings. Due exploitation, abuse ar with staff and the imple behaviors that need to being aware of a clier and Program Director.	ne consumers in your care? 0203 (V109): Competencies nals and Associate ECTION: Case responsible training of PCP guidelines v; this process will be the Program, Clinical sining will include aviors that are addressed fied as a need in the PCP the changed, revised and/or the retrained in exploitation, the to the indirect involvement Lead QP's daughter's car. the begin with Lead QP and the tor for a minimum of two that to monthly to oversee and general policies and tracked as needed." 0204 Competencies tracked as needed." 0205 Tracked as needed." 0206		This has been addressed with QP and meetings throughout the month of Oct Staff will immediately reach out to thei supervisor or on-call staff when direct staff do not show up or identify that the be late for their shift. Supervisor or onstaff will immediately find a replaceme fill in at the group home until one arriv will hold QP accountable of requirementhroughout the weekly meetings and QP rogram director will attend the upcommonthly meetings. During these meeti exploitation, abuse and neglect will be reviewed with staff and the importance identifying behaviors that need to be addressed on and being aware of a clip PCP including goals. QI and Program will review the needs of ensuring staff adequate notice when they are calling their shift. Will review with direct care needs they need to meet their goals of sight (supervision of clients), calling immediately when staff doesn't come is work	ober. r care ey will -call nt and es. We nts QI and ning ngs, e of  dent's Director provide in for staff the i.e. line	10/26/2021

Division of Health Service Regulation

STATE FORM 6899 NBPP11 If continuation sheet 37 of 79

Division of Health Service Regulation

	or riealth Service Regu					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	=160
		MHL012-137	B. WING	<del></del>	10/05/2021	
NAME OF D		etpeet AD	ODESS CITY ST	ATE ZID CODE	·	
NAIVIE OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	ATE, ZIP CODE		
PARK PLA	ACE	109 PARK		_		
		MORGAN	TON, NC 2865	5		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE
IAG	NEODE TOTAL		TAG	DEFICIENCY)	W (1 L	
V 170	0	- 07	V 179			
V 179	Continued From page	e 37	V 179			
		shift. Will review with direct				
	care staff the needs t	hey need to meet their goals				
	- i.e. line of sight (supervision of clients), calling					
	immediately when sta	aff doesn't come into work."		0.50		
	-(C) "10A NCAC 27G.0205(c) (V112): Assessment and Treatment/Habilitation or			Staff will provide the client with a 30 day on notice and then apply for a waiver to exte		
				client's stay in the program when placement		
	Service Plan. CORRE	ECTION: Staff will provide		problematic. This waiver will be provided		
		ay discharge notice and then		respective MCO and DHSR. QP will go th		
		extend the client's stay in the		the PCP training, particularly regarding a		10/05/2021
	-	ment is problematic. This		member's needs are identified in the plan, even as		
		waiver will be provided to the respective MCO and DHSR. Laurenda will go through the PCP and DHSR. Laurenda will go through the PCP and DHSR. Laurenda will go through the PCP				
		egarding a member's needs		immediate emergency CFT meeting will o		
	_ ·	lan, even as new issues		address the behaviors.		
		lan to update the PCP at the				
		less the behavior requires				
	_	ge - and an immediate				
		ting will occur to address the				
	behaviors."					
	-(D) "10A NCAC 27G			At all times, at least one direct care staff m		
		l times, at least one direct		shall be present with every four children of adolescents. If the ratio is 5 or 6 there sha		
		all be present with every		staff available at all times. If children or	ii be two	
		scents. If the ratio is 5 or 6		adolescents are cared for in separate build	lings, the	
		iff available at all times. If		ratios shall apply to each building. Manage		
		its are cared for in separate		Lead QP, QI Director and Program Director		
		hall apply to each building.		notified immediately when there is a staff s		10/05/2021
	Management - Lead			or a staff no-show for their shift. This will e appropriate staffing ratios are always mair		
	•	be notified immediately		keeping with the safety of the clients being		
		shortage or a staff no-show		If coverage is not available, then one of the		
		ll ensure appropriate staffing		mentioned management positions will be r	equired	
		ntained in keeping with the		to cover until appropriate staffing ratios ca		
	_	eing served. If coverage is		achieved. The goal is to have staff ratios n times in keeping with agency policy and pr		
	1	ne of the above mentioned		and State and Federal regulations. Two st		
		ns will be required to cover		scheduled at all times during awake hours		
		ing ratios can be achieved.				
	_	taff ratios met at all times in				
		policy and procedure and				
		gulations. Two staff will be				
		s during awake hours."				
	-(E) "10A NCAC 27G	.1303(d) (V182): Operations.	1			1

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 38 of 79

Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE S	
			A. BOILDING.	<del></del>		
		MHL012-137	B. WING		10/0	05/2021
NAME OF D		CTDEET ADI	DDECC CITY CT	ATE 7/D CODE	<u></u>	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	ATE, ZIP CODE		
PARK PLA	ACE	109 PARK		_		
			TON, NC 2865			
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 179	is approaching his 18 notify the Managed C get approval for servi discharged by the 6 n birthday or the end of (whichever is longer). clients having this iss requested from DHSF maintain the client un can be obtained. Wai ongoing basis to ensu	e future when an adolescent th birthday Focus BHS will are Entity for the client and ces if the client cannot be nonths after their 18th the state fiscal year In addition, for all future ue a Waiver will be R so that the agency can til appropriate placement vers will be completed on an ure the agency is approved	V 179	In the future when an adolescent is appro- 18th birthday Focus BHS will notify the MacCare Entity for the client and get approval services if the client cannot be discharged months after their 18th birthday or the end state fiscal year (whichever is longer). In a for all future clients having this issue a Wa be requested from DHSR so that the ager maintain the client until appropriate placer be obtained. Waivers will be completed or ongoing basis to ensure the agency is app go outside the limits of the statutory requir Program director will be responsible for ov ensuring that the MCO and DHSR are aw need to continue providing services until p can be found.	anaged for by the 6 l of the addition, siver will acy can ment can a an proved to rements. versight are of the	10/205/2021
	and DHSR are aware providing services un -(F) "10A NCAC 27G Requirements for Cat (V366) AND 10A NCA Reporting Requireme Providers (V367). CC policy and procedure will follow all statutory to reporting of serious incidents must be rep QI Director and NC P Program Manager - C for reporting to approinvestigation, obtaining statements. At no time more than 24 hours to serious nature. Report follow 27G.0604 for reexcept deaths, that of billable services or the providers premised level II deaths involving the Carlotte services under the control of the control of the control of the control of the carlotte services or the providers premised level II deaths involving the carlotte services under the carlotte services under the carlotte services or the carlotte services under the carlot	m director will be ght ensuring that the MCO of the need to continue til placement can be found." .0603 Incident Response egory A and B Providers AC 27G .0604 Incident nts for Category A and B PRECTION: Per agency and APSM 30-1 the agency requirements as it relates incidents. All Level III orted within 24 hours to the rogram Director. The QP shall follow instructions priate entities, conducting		Per agency policy and procedure and 30-1 the agency will follow all statutor requirements as it relates to reporting serious incidents. All Level III incident be reported within 24 hours to the QI and NC Program Director. The Program Manager - QP shall follow instructions reporting to appropriate entities, cond investigation, obtaining client and staff statements. At no time will the Lead Comore than 24 hours to report any incidents as erious nature. Reporting requirements follow 27G.0604 for reporting Level II incidents, except deaths, that occurring the provision of billable services or who consumer is on the providers premised Level III incidents and level II deaths in the clients to whom the provider rendesservice within 90 days prior to the incident LME responsible for the catchmer where services are provided within 72 becoming aware of the incident. If the aware on day 1 then the lead WILL mereport within 24 hours or immediately required entities. The investigative remust all be completed according to agand State and Federal requirements. director will monitor Lead QP and QI of	of s must Director am s for ucting f P wait dents of ents shall ag during hile the ss or nvolving ered any dent to ht area hours of lead is ake the to all ports gency Program	10/22/2021

Division of Health Service Regulation

to the incident to the LME responsible for the

STATE FORM 6899 If continuation sheet 39 of 79 NBPP11

to ensure that reports are dated.

Division of Health Service Regulation

Division of	ot Health Service Regu	ilation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
		MHL012-137	B. WING		10/0	5/2021
		WITE012-137			10/0	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
PARK PLA	VCE	109 PARK	ER LANE			
I AIRICI LA		MORGAN	TON, NC 2865	5		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	REGULATORTORT	EGG IDENTIF TING INFORMATION)	TAG	DEFICIENCY)	INIL	5,2
1/ 470	0 " 15		1/470			
V 179	Continued From page	e 39	V 179			
		e services are provided				
	within 72 hours of bea					
	incident. If the lead is	aware on day 1 then the				
	lead WILL make the r	report within 24 hours or				
	immediately to all req	uired entities. The				
	investigative reports i	must all be completed				
	according to agency	and State and Federal				
	requirements. Progra	m director will monitor Lead				
	QP and QI director to	ensure that reports are				
	dated."			There shall be no further financial trans	eactions	
	-(G) "10A NCAC 27F	.0105 Client's Personal		between any clients of Focus and direct		
	Funds (V542). CORF	RECTION: There shall be no		They shall follow already established F	ocus	
	further financial trans	actions between any clients		Policies around management of client		
	of Focus and direct s	taff or their family. They shall		This was addressed with the staff in qu		
	follow already establi	shed Focus Policies around		upon their return from vacation and pe		
	management of clien	t funds. This shall be		action shall accompany that. Further, v		
	_	taff in question upon their		clients maintain jobs and have bank ac		
		and personnel action shall		staff shall do financial counseling and		
		ther, when clients maintain		the ADL Client Training handbook for e	ensuring	
		accounts, staff shall do		they are able to manage their own fund		
	financial counseling a	and follow the ADL Client		There will be documentation kept withi		
	_	r ensuring they are able to		client's medical record that these issue		10/11/2021
	manage their own fur	nds. There will be		been addressed. Should a client have		
		vithin the client's medical		in maintaining their finances and finance		
	record that these issu	ues have been addressed.		wellbeing then a financial trustee and/o		
	Should a client have	difficulty in maintaining their		guardian shall be established within the agency to manage those funds for their		
	finances and financia	l wellbeing then a financial		must follow our agency policy around	II. VVC	
	trustee and/or guardia	an shall be established		management of client funds and maint	aining	
	within the agency to r	manage those funds for		records of any financial transactions. T		
	them. We must follow	our agency policy around		be the Lead QP. The lead QP will rece		
	management of clien	t funds and maintaining		supervision around these issues. The		
	records of any financ	ial transactions. This may be		exploitation, neglect and abuse policie	s will be	
	the Lead QP. The lea	ad QP will receive		reviewed by Program Director with the	Lead	
	supervision around th	nese issues. The		QP, with direct care staff at the next st		
	exploitation, neglect a	and abuse policies will be		meeting that occurs this month and ag		
	reviewed by Program	Director with the Lead QP,		wide for management staff. A refreshe	r class	
		at the next staff meeting that		will occur by the end of October.		
	occurs this month and					
		refresher class will occur by				
	the end of October."	-				

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 40 of 79

Division of Health Service Regulation

DIVISION	of Health Service Regu	lation				
	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
		NULL 040 407	B. WING		40/07/0004	
		MHL012-137	D: Wiito		10/0	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
		109 PAR	ER LANE			
PARK PLA	ACE		TON, NC 2865	5		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
				The North Carolina Program Director, in		
V 179	Continued From page	e 40	V 179	Partnership with the Quality Improvement	(QI)	
	-(2) Describe your pla	ans to make sure the above		Director will be solely responsible for overs		
	happens.	and to make date the above		ensuring all areas of the plan of protection		
	-" The North Carolina	Program Director in		adhered to and enforced according to Stat		
		Quality Improvement (QI)		Federal and agency policy and procedure.		
		responsible for oversight		Timelines of all plans of protection will be f		
	-	· · · · · · · · · · · · · · · · · · ·		implemented and corrected within a maxin days timeline from the date of this plan of	1um 01 45	
		s of the plan of protection		protection. All supporting documentation t	o show	
		nforced according to State,		enforcement of this Plan of Protection will		
	Federal and agency p			readily available upon request by DHSR a		
		of protection will be fully		MCO. Final maximum timeline for all items		
	-	rected within a maximum of		implemented and followed will be Decemb		
		the date of this plan of		November 18, 2021. If possible, all POP it		
		rting documentation to show		be implemented much earlier. The followin implemented immediately and throughout		40/04/0004
		lan of Protection will be		-(A)"The NC Director will begin monthly	2021.	12/04/2021
		n request by DHSR and/or		unannounced visits to the Park Place facili	itv to do	
		n timeline for all items wot be		random reviews, client interviews, supervis		
	-	owed will be December		floor staff and oversight of the Qualified		
		If possible, all POP items		Profession."		
	· -	nuch earlier. The following		-(B)"QI Director will meet and discuss wee	kly	
		mmediately and throughout		updates and issues regarding this Plan of Protection as needed."		
	2021":			-(C)More intense training and clinical supe	rvision	
	-(A)"The NC Director			around this plan of protection will begin with		
	unannounced visits to	the Park Place facility to do		Qualified Professional, starting Thursday (	October	
	random reviews, clier	nt interviews, supervision of		7, 2021 and every Thursday thereafter for	up to 2	
	floor staff and oversig	ht of the Qualified		months."	. 4	
	Profession."			-(D)The NC Program Director and QI Director attend monthly staffing meetings-October 3		
	. ,	neet and discuss weekly		9am to 11 am and following meetings in N		
	updates and issues re			and December 2021		
	Protection as needed	."				
		ining and clinical supervision		Program Director has visited the facility for		
		otection will begin with the		month of October on the 28th and has bee	en	
	Qualified Professiona	ıl, starting Thursday October		meeting weekly.		
	7, 2021 and every Th	ursday thereafter for up to 2				
	months."					
	-(D)"The NC Program	n Director and QI Director				
		affing meetings-October 26,				
		nd following meetings in				
	November and Decer					
	Clients #1, #2, #3, #4	, #5, Former Client (FC) #6,				
		age from 14-19 years old				

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 41 of 79

Division of	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
			D WING			
		MHL012-137	B. WING		10/0	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		109 PAR	KER LANE			
PARK PLA	ACE		NTON, NC 2865	5		
(VA) ID	SLIMMADV ST.	ATEMENT OF DEFICIENCIES	<u>,                                      </u>	PROVIDER'S PLAN OF CORRECTIO	nNI	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE	DATE
				DEFICIENCY)		
V 179	Continued From page	Δ1	V 179			
	. •					
		h diagnoses including, but				
	not limited to, Adjustn	nent Disorder,				
	Attention-Deficit Hype	eractivity Disorder (ADHD),				
	Bipolar Disorder, Auti	sm Spectrum Disorder,				
	Conduct Disorder Chi	ildhood onset,				
	Post-Traumatic Stres	s Disorder, and Oppositional				
		y had extensive histories of				
		ehaviors, self-injurious				
		ment. Client #2 was 16				
		ses of Bipolar Disorder,				
		order, Personal history of				
		onal history of psychological				
		cumstances related to child				
		ator. He began to exhibit				
		urinating in his room and				
	leaving the facility wit					
	treatment plan was no					
		nclude sexualized behaviors				
		ey arose. More so, the facility				
		ice staff shortages and				
	supervision deficits, v					
		unity for Client #2 to leave				
		rmission and unsupervised				
		2) was later found down the				
		#6 was 16 years old with				
		-				
		ve Mood Dysregulation				
	Disorder (DMDD), OE	nduct Disorder (Adolescent				
	·	,				
		plations of rules) and FC #7			ľ	
	was 16 years old with	-				
	Persistent Depressive					
	disorder) and ODD (A	- · · · · · · · · · · · · · · · · · · ·				
	,	here was allegation of			ľ	
		ning to FC #6 and FC #7 on			ľ	
		he alleged victim was forced				
		e facility with his (FC #6)				
	alleged offender. FC	<del>-</del>			ľ	
	aggressively toward F	FC #7 (alleged offender),				

Division of Health Service Regulation

which resulted in FC #6 being involuntarily committed, thus providing the separation between

STATE FORM NBPP11 If continuation sheet 42 of 79

Division of	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL012-137	B. WING		10/0	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		109 PARK				
PARK PLA	ACE	MORGAN	TON, NC 28655	5		
(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	(X5) COMPLETE DATE
V 179	Continued From page	÷ 42	V 179			
	the alleged victim and began to exhibit persidirected toward staff arriving at the facility. to develop goals and sexualized behaviors began, which led to to 06/02/2021. FC #8 was who turned 18 years admission into the facility to ensure the collents around the sar protective measures of facility to ensure the correction of the adole FC #8, who had a per influenced but the facility to purchase the granddaughter, who woring. The QP did rand/or administrative the needs of Client #2 include but not limited to address behavioral resulting in continued used her influence to her granddaughter's wexploitation. The facilithorough and efficient alleged sexual assaul by their policy and proalso did not implement procedures, which results and exploitation of incomments.	d offender. In addition, FC #7 istent sexualized behaviors and peers within weeks of However, the facility failed strategies to address those clinically when they initially the alleged sexual assault on as a registered sex offender old, 2 months prior to clity. FC #8, a competent to integrate and interact with me age of his victims. No were put in place by the continued safety and escents served. In addition, resonal vehicle was idlity's Qualified Professional vehicle of her (the QP) was in the process of not provide the clinical oversight required to meet 2, FC #6, #7 and #8 to d to updating treatment plans and difficulties as they arise neglect. More so, the QP organize the purchase of vehicle by FC #8, resulting in ity did not complete a trinvestigation into the lation 06/02/2021 as specified ocedures. In addition, they not written policies and sulted in continued neglect dividuals served.	V 179			
	corrected within 23 da	ays. An administrative s imposed. If the violation is				

Division of Health Service Regulation

STATE FORM 6899 NBPP11 If continuation sheet 43 of 79

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	
		MHL012-137	B. WING		10/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	
PARK PLA	ACE		KER LANE NTON, NC 2865	5	
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
V 179		of \$500.00 per day will be the facility is out of	V 179		
V 180	minimum of two years adolescent services a preparation in adminimork, nursing, psycho (b) At all times, at least member shall be presor adolescents. If chicared for in separate apply to each building (c) When two or more an emergency on-cal available by telephon the facility within 30 m	have a director who has a sexperience in child or and who has educational stration, education, social plogy or a related field. The ast one direct care staff sent with every four children lidren or adolescents are buildings, the ratios shall die clients are in the facility, a staff shall be readily e or page and able to reach ininutes.	V 180		
	This Rule is not met Based on record revie facility failed to ensure one direct care staff v children or adolescen clients (Clients #1, #2 findings are:	as evidenced by: ews and interviews, the e that at all times at least vas present with every four ts affecting five of five		At all times, at least one direct care staff me shall be present with every four children or adolescents. If the ratio is 5 or 6 there shall staff available at all times. If children or adolescents are cared for in separate buildi ratios shall apply to each building. Manage Lead QP, QI Director and Program Director notified immediately when there is a staff shor a staff no-shows for their shift. This will appropriate staffing ratios are always maintakeeping with the safety of the clients being of the coverage is not available then one of the mentioned management positions will be read to cover until appropriate staffing ratios can achieved. The goal is to have staff ratios must times in keeping with agency policy and propand State and Federal regulations. Two states scheduled at all times during awake hours.	be two  ngs, the ment - will be nortage ensure ained in served. above quired be net at all needure

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 44 of 79

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	MHL012-137	B. WING		10/05/2021	
NAME OF PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	TE, ZIP CODE		
PARK PLACE	109 PARI	KER LANE			
.,	MORGAN	ITON, NC 28655			
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 180 Continued From	page 44	V 180			
-Admission date -Age 15 yearsDiagnoses of Ad anxiety/depresse Attention-Deficit I combined type.  Review on 09/16, #2's record reveal -Admission date -Age 16 yearsDiagnoses of Bij Disorder, Person personal history of other circumstant abuse-perpetrato  Review on 10/5/2 -Admission date -Age 16 yearsDiagnoses of Diagnoses of Diagnoses of Diagnoses of Diagnoses of Diagnoses of Coand Post-Trauma  Review on 10/5/2 -Admission date -Age 14 yearsDiagnoses of Coand Post-Trauma  Review on 10/5/2 -Admission date -Age 14 yearsDiagnoses of Diagnoses of Diagnoses, Conductive Diagnoses, Conductiv	Justment Disorder - mixed d mood, Primary Insomnia, and Hyperactivity Disorder (ADHD)-  2021 and 09/17/2021 of Client led: of 7/23/2021.  Joolar Disorder, Autism Spectrum al history of self-harm, other of psychological trauma, and less-child sexual r.  1 of Client #3's record revealed: of 06/03/2021.  Suruption of family by separation er specified trauma-and Disorder, Child sexual abuse, encounter, ADHD - combined child relational problem.  1 of Client #4's record revealed: of 08/10/2021.  Induct Disorder Childhood onset tic Stress Disorder.  1 of Client #5's record revealed:	V 160			

Division of Health Service Regulation

Interview on 09/15/2021 with Staff #1 revealed:

STATE FORM NBPP11 If continuation sheet 45 of 79

Division of	<u>of Health Service Regu</u>	llation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		MIII 040 407	B. WING		40/05/0004	
		MHL012-137	B. WC		10/05/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
		109 PAR	KER LANE			
PARK PLA	ACE		ITON, NC 2865	5		
0(0)15	QUMMADV QT	ATEMENT OF DEFICIENCIES	· ·	PROVIDER'S PLAN OF CORRECTION	1 0/5	—
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	()	Ξ
TAG	•	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		
				DEFICIENCY)		
V 180	Continued From page	2.45	V 180			$\neg$
V 100			100			
		itored at all times and never				
	be unsupervised.	فسدناه مطففينط مسمام مامنعف				
		itside alone, but the client				
	must remain in his lin	•				
		as monitoring other clients de the facility and also				
	•	(who was outside) through a				
	window.	(who was outside) through a				
	-" He (Client #2) was	taking a 5-10 minute				
	timeout outside, but it ended up being an hour. I saw him walk off."					
	-Noticed Client #2 wa	as no longer in his (Staff #1)				
	line of sight, informed	I his co-worker (Staff #4)				
	and then went to look	for Client #2 in the facilty's				
	vehicle.					
	-Found Client#2 playi bottom of the street.	ing in the creek at the				
	-"Typically, there is a	two hour gap" on Sunday				
	where he was the onl					
	-The second staff me	mber comes in at 11 am				
	and works until 9 pm.					
	-He usually just had t	he clients stay in bed until				
	10:30 am which was	breakfast time.				
	Intoniow on 00/27/20	021 with Staff #4 revealed:				
		sion expectation was to have				
	the clients in our sigh	•				
		ring the 09/12/2021 incident.				
		Client #2 was seated at				
	picnic table outside.					
	-Checked on him eve	erv 2-3 minutes.				
	-Last check he was g					
		Professional (QP) and was				
	informed to call 911.	. ,				
	-Staff #1 went to look	for Client #2 in the facilty's				
	van.	-				
		021 with Staff #2 revealed:				
	-Clients must be mon					
	-Staff did a head cour	nt every 5 minutes to ensure				

Division of Health Service Regulation

STATE FORM 6899 NBPP11 If continuation sheet 46 of 79

Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURV	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETE	D
		MHL012-137	B. WING		10/05/2	2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	FE, ZIP CODE		
		109 PARK	(ER LANE			
PARK PLA	ACE		TON, NC 28655			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG	· · · · · · · · · · · · · · · · · · ·	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	DATE
V 180	Continued From page	e 46	V 180			
		nere are times when it is and Sunday; 1 staff is left				
	QP revealed:	221 and 09/21/2021 with the as needed) staff members				
	that worked on Sunday; their hours were 12 noon to 6 pmStaffing ratio for the facility was 1:6Sunday was the only day, 2 staff were not on duty at all times.					
	Interview on 09/21/2021 with the facility's NC Program Director revealed: -She was not aware of the 2-3 hour gap in staffing on Sundays.					
	little late to her"The minute the clier	ning in at 11 am sounded a  nts feet hit the floor (get out be a second staff there."				
	-They have had troub to Covid 19.	staffing then "we need to				
	look at the reason for					
	NCAC 27G .1301 Sco	ss referenced into 10A ope (V179) for a Type A1 st be corrected within 23				
V 182	27G .1303 (B-G) Res	idential Tx - Operations	V 182			
	other responsible adu	ent. Family members or ults shall be involved in s in order to assure a smooth				

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 47 of 79

Division c	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
		MHL012-137	B. WING		10/0	5/2021
		WIFIL012-137			10/0	5/2021
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		109 PARKE	R LANE			
PARK PLA	ACE	MORGANT	ON, NC 2865	5		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N .	(75)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
			1	DEFICIENCY)		
V 182	Continued From page	e 47	V 182			
	. •					
	(c) Education. Childi					
		al treatment facility shall				
		ducational services, either				
	0	ed school, 'home-based'				
		a day treatment program.				
	•	school setting shall be part				
	of the treatment plan.  (d) Age Limitation. If an adolescent has his 18th birthday while receiving treatment in a residential facility, he may continue in the facility for six months or until the end of the state fiscal year,					
		nd of the state fiscal year,				
	whichever is longer.	hild or adalogoopt shall have				
		hild or adolescent shall have shall have training and help				
	in its selection and ca					
	(f) Personal Belongir					
		ntitled to age-appropriate				
		unless such entitlement is				
	counter-indicated in the					
	(g) Hours of Operation	•				
		day, at least five days per				
		eks per year, excluding legal				
	holidays.	eks per year, excluding legal				
	nolidays.					
				In the future when an adolescent is		
				approaching his 18th birthday Focus E	3HS will	
				notify the Managed Care Entity for the		
				and get approval for services if the clie		
	This Rule is not met	as evidenced by:		cannot be discharged by the 6 months	s after	
		ews and interviews, the		their 18th birthday or the end of the st		
	facility failed to assure			fiscal year (whichever is longer). In a		10/05/2021
	•	in a 1300 facility affecting 1		for all future clients having this issue a		10/00/2021
		FC) audited (#7). The		will be requested from DHSR so that t	he	
	findings are:	c,		agency can maintain the client until	- al	
				appropriate placement can be obtained		
	Review on 09/16/202	1 of FC #7's record		Waivers will be completed on an ongo basis to ensure the agency is approve		
	revealed:			outside the limits of the statutory	tu to go	
	-Admission date of 02	2/28/2020		requirements.		
	, talling 51. 52.			requirements.		

Division of Health Service Regulation

-Discharge date of 08/10/2021.

STATE FORM 6899 NBPP11 If continuation sheet 48 of 79

Division of	<u>of Health Service Regu</u>	lation				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE SU COMPLE	
		MHL012-137	B. WING		10/0	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
PARK PLA	ACE		KER LANE			
		MORGAN	NTON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY 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 182	Continued From page	Continued From page 48				
	Disorder (ADHD), Op (ODD), and Generaliz-Commprehensive CI addendum dated 07/2 coming to Focus, [FC first degree statutory in sexually inapproprisiblings and misuse of the home after being a result, [FC#8] was proffender Registry at the sexual popular of the sexual options in find community once held of the sexual definition of the sexual behaviors, this sexual behaviors of the sexual behavio	linical Assessment (CCA) 26/2021 specified, "Prior to 2#8] had been charged with sexual offense for engaging iate behaviors with his of 911. [FC#8] reoffended in placed on probation and, as placed on the NC Sex the age of 15." fender registry has limited ding placement in the eaves level 2"  221 with the Qualified vealed: could remain in the facility ars old because this was a on life skills that prepared the ful in the community.  221 with the Quality rector revealed: a facility for clients with as was their Level III facilities. Level II facility was 12-21 set that had resided at the see; he could not go home here his victims were - his sex offender registry and this				

Division of Health Service Regulation

Carolina (NC) Program Director revealed:

STATE FORM 6899 NBPP11 If continuation sheet 49 of 79

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING			
		MHL012-137	B. WING		10/05/202	21
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PARK PLA	ACE	109 PARKE				
			ON, NC 28655			
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COM	(X5) MPLETE DATE
V 182	finishing their Level II -Due to him being a re it was impossible to fi -The QP probably app and he kept being der -The goal was to get I would have been hom incarceratedThe Local Managem of his extended stay a	down after successfully I program. egistered adult sex offender and placement. blied to more than 50 places anied. anim out much sooner, but he aneless and then possibly ent Entity (LME) was aware	V 182			
V 366		•	V 366			
	RESPONSE REQUIR CATEGORY A AND B (a) Category A and B implement written pol response to level I, II shall require the provi (1) attending to of individuals involved (2) determining (3) developing measures according t timeframes not to exc (4) developing to prevent similar inci specified timeframes (5) assigning po for implementation of preventive measures; (6) adhering to	REMENTS FOR PROVIDERS providers shall develop and dicies governing their or III incidents. The policies der to respond by: the health and safety needs in the incident; the cause of the incident; and implementing corrective to provider specified the eed 45 days; and implementing measures dents according to provider mot to exceed 45 days; terson(s) to be responsible the corrections and				

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 50 of 79

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL012-137	B. WING		10/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
PARK PLA	ACE	109 PAR	(ER LANE		
		MORGAN	ITON, NC 28655	<b>i</b>	
(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 APPROPF DEFICIENCY)	BE COMPLETE
V 366	Continued From page	e 50	V 366		
V 366	42 CFR Parts 2 and 3 164; and (7) maintaining Subparagraphs (a) (1) (b) In addition to the Paragraph (a) of this shall address inciden regulations in 42 CFF (c) In addition to the Paragraph (a) of this providers, excluding I develop and impleme their response to a le while the provider is o or while the client is o The policies shall req by: (1) immediately by: (A) obtaining the (B) making a pi (C) certifying th (D) transferring review team; (2) convening a review team within 24 internal review teams who were not involve were not responsible with direct profession services at the time o review team shall cor follows: (A) review the o determine the facts a	documentation regarding through (a)(6) of this Rule. requirements set forth in Rule, ICF/MR providers ts as required by the federal R Part 483 Subpart I. requirements set forth in Rule, Category A and B CF/MR providers, shall ent written policies governing wel III incident that occurs delivering a billable service on the provider's premises. uire the provider to respond a securing the client record to e client record; thotocopy; the copy's completeness; and the copy to an internal a meeting of an internal a hours of the incident. The shall consist of individuals d in the incident and who for the client's direct care or all oversight of the client's f the incident. The internal implete all of the activities as opy of the client record to and causes of the incident dations for minimizing the	V 366		
	(B) gather other	r information needed; n preliminary findings of fact			

Division of Health Service Regulation

STATE FORM 6899 NBPP11 If continuation sheet 51 of 79

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
			B. WING			
		MHL012-137	D. WING		10/0	5/2021
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
PARK PLA	ACE	109 PARK				
			TON, NC 28655			
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 366	Continued From page	<del>2</del> 51	V 366			
	within five working da preliminary findings of LME in whose catchmolocated and to the LM if different; and (D) issue a final owner within three modinal report shall be secatchment area the public document area the public document include all public document and shall mark minimizing the occurrial documents needed available within three LME may give the protect three months to submodified (A) the LME researea where the service Rule .0604; (B) the LME who different; (C) the provider for maintaining and uptreatment plan, if different provider; (D) the Departmodicable; and	ys of the incident. The fact shall be sent to the nent area the provider is IE where the client resides, written report signed by the onths of the incident. The ent to the LME in whose rovider is located and to the resides, if different. The all address the issues nal review team, shall uments pertinent to the ake recommendations for ence of future incidents. If d for the report are not months of the incident, the ovider an extension of up to not if the final report; and on to if ying the following: ponsible for the catchment these are provided pursuant to the report of the catchment the same provided pursuant to the report of the catchment the same provided pursuant to the report of the catchment the same provided pursuant to the report of the catchment the same provided pursuant to the report of the catchment the same provided pursuant to the report of the catchment the same provided pursuant to the report of the catchment the same provided pursuant to the report of the catchment the client resides, if the report of the				

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 52 of 79

Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION (X3		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		MHL012-137	B. WING		10/0	5/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
DADK DI A		109 PAR	(ER LANE			
PARK PLA	ICE.	MORGAN	ITON, NC 2865	5		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	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 APPROPI DEFICIENCY)	BE	COMPLETE DATE
V 366	Continued From page	e 52	V 366			
	facility failed to implet governing responses incidents. The finding	ews and interviews, the ment their written policies to level II and level III		Per agency policy and procedure and AP the agency will follow all statutory require it relates to reporting of serious incidents. Level III incidents must be reported within hours to the QI Director and NC Program The Program Manager – QP shall follow instructions for reporting to appropriate e conducting investigation, obtaining client	ements as All 1 24 Director.	
	Health Services (Lice Policy with effective of "The employee who incident or to whom a client, visitor, or other responsible for the initincident."	Incident Reporting late 07/31/2017 revealed: discovers or witnesses an in incident is reported by a ronn-employee, is itial documentation of the dent report form will be ity Improvement		statements. At no time will the Lead QP more than 24 hours to report any incident serious nature. Reporting requirements of follow 27G.0604 for reporting Level II incidence except deaths, that occurring during the post of billable services or while the consumer providers premises or Level III incidents as II deaths involving the clients to whom the provider rendered any service within 90 to the incident to the LME responsible for catchment area where services are providered.	wait ts of a shall idents, provision r is on the and level e days prior the ded	10/05/2021
	documentation is ade follow-up action was i -"The Client Rights C for review, evaluation appropriate investigat to specific Level II inc incidents. A verbal re designated staff to the on a quarterly basis."	equate and immediate initiated as needed." ommittee will be responsible and ensuring an tion was conducted related cidents and all Level III port will be given by a e Client Rights Committee		within 72 hours of becoming aware of the If the lead is aware on day 1 then the lea make the report within 24 hours or immed all required entities. The investigative repmust all be completed according to agen. State and Federal requirements. Program will monitor Lead QP and QI Director to ethat reports are dated.	d WILL diately to corts cy and n Director	
	involving the following Client Rights Commit -(a) actual or alleged -(b) abuse, neglect, o	client right violations. r exploitation.				
	behavioral intervention -(d) injury requiring transfers aid resulting from of the intervention(e) incidents reported Services (DSS) that of	eatment, other than minor				

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 53 of 79

Division of Health Service Regulation

MHL012-137  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  109 PARKER LANE	2021
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  109 PARKER LANE	2021
109 PARKER LANE	2021
109 PARKER LANE	
PARK PLACE MORGANTON, NC 28655	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366 Continued From page 53 V 366	
services were being rendered or involve staff.  -"Incidents involving clients will be reported to the facility Supervisor and the Quality Improvement Director within 24 hours."  -Reporting Category II Incidents:  -"(1) Notify the facility supervisor within 24 hours and document in IRIS."  -"(2) The IRIS report must be reviewed by the supervisor and submitted within 72 hours of the incident."  -"(3) The facility supervisor must verbally notify the Quality Improvement Director within 24 hours or the next business/working day".  -"(4) A copy of the incident report must be forwarded to the Quality Improvement Director within 72"  -"(8) The information will be reviewed at the next scheduled Committee meeting and a report will be given to the Quality Improvement Committee by the Client Rights Committee Chairperson."  -Reporting Category III Incidents: -"(1) Notify the supervisor within 12 hours and document in IRIS (Incident Response Improvement System)."  -"(2) The facility supervisor/team leader must notify their responsible supervisor through the appropriate chain of command and the clinical on-call staff within 24 hours.  -"(3) During normal hours of operation the Clinical Director and Quality Improvement Director must be verbally notified of the Incident within 24 hours.  During afterhours (evening, and weekends) the after-hours emergency contact will be notified within 24 hours who will in turn notify the Clinical Director and Quality Improvement Director. The agency Board of Directions shall be notified of all Level III incidents as appropriate" -"(5) A copy of the incident report must be	

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 54 of 79

Division of Health Service Regulation

Division of Health Service Regulation						
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (	F CORRECTION	DENTIFICATION NUMBER:			COMPLETED	
			A. BOILDING.			
		MHL012-137	B. WING		10/0	5/2021
			Į		1 10/0	, O, E O E 1
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		109 PARK	FRIANF			
PARK PLA	<b>ICE</b>			=		
		WORGAN	TON, NC 2865			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PRÉFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	₹IATE	DATE
				DEFICIENCY)		
V 266	Continued Frame none	- 51	V 366			
V 366	Continued From page	9 54	V 300			
	within 72 hours."					
		ncidents will be reviewed by				
	the Client Rights Con					
	•	r will ensure that all pertinent				
	information is shared	with the Committee during				
	their review."					
	-"(7) If warranted the	Client Rights Committee will				
		nation or investigation of the				
	•	terventions utilized and				
		en. The Client Rights and				
		•				
	-	Committee will report to the				
		committee regarding the				
	review, recommendate	tions, or further actions				
	taken."					
	-"(9) AWOL (Absent V	Nithout Leave) > 3 hours or				
		uires police contact"				
	-Investigations:	unes ponde dontact				
		ement Director or designee				
		cident investigation within 10				
		e receipt of incident report				
	and develop a report	of investigation findings and				
	timeline of events to b	be submitted to the Area				
	Authority Client Right	s Department and the				
	Division of Health Ser					
	applicable)"	rvios regulation (ii				
	арриоаыс)					
	Daviou on 00/46/000	1 and 00/17/2024 of Client				
		1 and 09/17/2021 of Client				
	#2's record revealed:					
	-Admission date of 7/					
	-Diagnoses of Bipolar	r Disorder, Autism Spectrum				
	Disorder, Personal his	story (hx) of self-harm, other				
		ological trauma, and other				
	circumstances related	_				
		a to orning octual				
	abuse-perpetrator.					
		, <u>, , , , , , , , , , , , , , , , , , </u>				
		1 of Former Client (FC) #6's				
	record revealed:					
	-Admission date of 02	2/07/2021.				
	-Discharge date of 07					
		tive Mood Dysregulation				
	Diagnoses of Distup	avo moda bysiogaladon				

Division of Health Service Regulation

STATE FORM 6899 NBPP11 If continuation sheet 55 of 79

Division of Health Service Regulation

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		DATE SURVEY COMPLETED	
		MHL012-137	B. WING		10	/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE		
		109 PARI	KER LANE			
PARK PLA	ACE	MORGAN	NTON, NC 28655			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 366	Continued From page	± 55	V 366			
	Disorder (DMDD), Op (ODD), Attention Defi (ADHD)-Combined Pr	positional Defiant Disorder cit Hyperactive Disorder resentation, and Conduct onset with serious violations				
	Review on 09/16/202 revealed: -Admission date of 01-Discharge date of 6/3-Diagnoses of ADHD, Disorder (dysthymia of (Adolescent-onset type)	/29/2021. 30/2021. Persistent Depressive disorder); ODD				
	county of the facility, I licensee of the facility 06/01/2021-09/14/202 -Level III report entere 06/02/2021 incident re	21 revealed: ed on 06/08/2021 for egarding FC #6. IRIS for Client #2 regarding				
	facility's incident repo 09/14/2021 revealed: -Quality Improvement Level III IRIS report o incident regarding FC-The report indicated incident on 06/08/202-Sexual Abuse/Assau-The cause of the inci"Client [FC #6] had be by peer [FC #7]." -The incident prevent not inform staff of the by peer [FC #7]. Clie communicated and response of the communicated and response	(QI) Director submitted n 06/08/2021 for 06/02/2021 #6. the provider learned of the 1. lt/Rape was checked. dent was described as een repeatedly approached ion was "Client [FC #6] did previous advances made nt should have				

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 56 of 79

Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		MHL012-137	B. WING		10	/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	E, ZIP CODE		
	ACE	109 PAR	KER LANE			
PARK PL	ACE	MORGAI	NTON, NC 28655			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
V 366	Continued From page	e 56	V 366			
	of sharing information he feels uncomfortab -Incident comments be Entity (LME) dated 06 document how the coissues are being addi-There were no updar provider after 06/11/2  Review on 09/17/202 investigation report (update) the QI Director reveal	n with adults he trusts when le." by the Local Management 6/11/2021 were "Please onsumer's health and safety ressed." ted comments by the 2021. If of the facility's undated) and completed by led:				
	the QI Director revealed:  -Name and identifying information for only FC #6 referenced.  -"Incident details: [FC #6] alleged that a peer attempted to pull his pants and underwear down and that he believed the peer wanted to perform fellatio on him."  -"Investigation: Statements were obtained by peers, staff, therapist and client. Please see attached."  -"Review Summary: Per the investigation reports					
	client was approache went into the first bed are no cameras. Clien walked into the bedro attempted to perform review of the camera block view of the hall One staff was sitting other was in the kitch boys were behind the client returning to the minute. This informat [FC #6] reported it or -Both staff on duty at up for failure to maint #6 and #7.	lient and staff, on June 2nd, d by a peer. Both clients froom on the left where there intreported that he willingly from with the peer who then fellatio on the client. In two doors were left open to way from the milieu area. The event where both two open doors and the milieu was less than a lion was not realized until in [Staff #1] June 6th."  It time of incident were written that in GP) informed all staff				

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 57 of 79

Division of Health Service Regulation

DIVISION	n nealth Service Negu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
			B. WING			
		MHL012-137	B: Wille		10/0	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		109 PARK	ER LANE			
PARK PLACE MORGAN		TON, NC 2865	5			
	CLIMMA DV CT		<del>.</del>			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD)		(X5) COMPLETE
TAG	•	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
V/ 266	0		V 266			
V 366	Continued From page	9 57	V 366			
	about the incident wh	en she learned about it (the				
	06/02/2021 incident).					
	-"[QP] informed them	that one of the staff were to				
	keep eyes on the acc	used at all times. IRIS was				
		ps were called due to the				
	alleged incident."					
	-On 06/08/2021, FC#	6 was involuntarily				
	committed due to ago					
		urned to the facility and was				
	` ,	iatric Residential Treatment				
	Facility on 07/12/202					
		not have a start or end				
	date.	The thave a start of one				
		nce an internal review team				
		of disclosure of the incident.				
		s of the incident were not				
	determined after the i					
	-Recommendations for	<del>-</del>				
	occurrences of future					
		incidents were not				
	documented.					
	Review on 09/17/202	1 of EC #6's typed				
		, ·				
	•	I dated 06/07/2021 revealed:				
		7:30 pm-8:00 pm FC #7				
		; #6) if he wanted oral sex.				
	He (FC #6) stated, "N					
	~	ed that night of 06/01/2021.				
		een 2:30 pm-4 pm while				
		n to whisper to him (FC #6),				
	•	e?, Can I at least give you				
	head?"					
	-"He (FC #6) respond					
		grab his (FC #6) private				
		C#6) swatted his hand and				
		nt back into to the facility				
	and began hygiene ro					
	-"FC #7 asked him (F	C #6) if he wanted a pair of				
	headphones and he (	FC #6) said No."				
	-After his shower he	noticed the headphones in				

Division of Health Service Regulation

his room.

STATE FORM 6899 NBPP11 If continuation sheet 58 of 79

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				B WING		
		MHL012-137	B. WING		10/05/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
PARK PLA	ACE	109 PARK	ER LANE FON, NC 28655	<b>.</b>		
()(1) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	<del></del>	PROVIDER'S PLAN OF CORRECTION	NI (VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
V 366	Continued From page 58		V 366			
	-While walking up the wrist/arm area and puempty room"[FC #7] then attemps shorts. He stated, 'He on his right side in the asked [FC #6], Why ore sponded, This shouth boys exit the round representation of the stated staff the headphones into trouble and did not in thitting [FC #6], because the statement signed and representation of the statement signed and represe	thallway, FC #6 grabbed his alled him (FC #6) into an off that the pull down his (FC #6) are rib cage. [FC #7] then did you do that?, [FC #6] all dhave never happened." om. he was going to give the but was fearful he would get out want to get in trouble for see his court date was the see his court date was the court date was the court date was, of oral sex when (QP) left my name and said yes he pecause he had it in three coutdoor rec (recreation), he he and said yes out of knew what he was referring to sit on the bench and called				
		1 of Client #3's handwritten				

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 59 of 79

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		MIII 040 407	B. WING			NO.5 (0.004
		MHL012-137	B. Wiito		10	)/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
PARK PLA	ACE		KER LANE			
	T	MORGAI	NTON, NC 28655			
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 366	Continued From page	e 59	V 366			
	he wanted a big long mustard. Now what h he said it made it a w [FC #7] like to stare. me at most time in wh	#7] stated in the milieu that hotdog with ketchup and e said in tale is ok, but how hole different issue. Also, I have visual boundaries with nich I walk by."				
	statement signed and dated 06/07/2021 revealed: -"[FC #6] connected with me on Sunday (06/06/2021) about what happened on Friday (06/04/2021)." -FC #6 revealed he attacked [FC #7], because he (FC #7) was coming on to him (FC #6)FC #7 asked him if he could give him head, whereas he (FC #6) said "No and that he was not					
	(FC #7) grabbed him inside the empty roor -"Then [FC #7] grabb	ed his pants and pulled his				
	#6] said that's when he pulled his pants back -"I asked [FC #6] why	he didn't report him (FC #7)				
	time because he was trouble with staff and	aid he didn't report it at the afraid that he would get in case worker. I (Staff #1) on conversation to my				
	statement signed and -On 06/01/2021, FC # knew what fellatio me -FC #7 asked (FC #6 -She intervened and -Later witnessed FC #6 if he wanted fellati	) if he did it or liked it. redirected FC #7. #7 from his doorway ask FC				

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 60 of 79

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL012-137	B. WING		10	0/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
PARK PL	ACE.	109 PAR	KER LANE			
FARR FL	HOE	MORGA	NTON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 366	progress note."  -On 06/02/2021 between don't recall what I was client engaging in any the doors were block the doors."  -QP signed document Review on 09/17/202 Professional's (QP) and dated 06/05/202 -On 06/04/2021 at 7 the inappropriate see: #5 and #6 that occur. No documented refusive (QP) notified oth Review on 09/23/202 Committee (CRC) M Virtual Meeting reversional Meeting rever	veen 4:00 pm-4:30 pm, "I as doing. I did not see either by inappropriate act. I did see do bathroom door open and king the hall camera, so I shut as a witness.  21 of the Qualified handwritten statement signed 21 revealed: 30 pm, she was informed of exual encounter between FC arred on 06/02/2021.  Berence as to who or when hers of the incident.  21 of Client Right's inutes from 08/25/2021 aled: 30 pm she was informed of exual encounter between FC arred on 06/02/2021.  Berence as to who or when hers of the incident.  21 of Client Right's inutes from 08/25/2021 aled: 30 pm she was informed of exual encounter between FC arred on 06/02/2021.  31 of Client Right's inutes from 08/25/2021 aled: 32 present and recorded the ext reports from April-June d.	V 366			

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 61 of 79

Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPL	EIED
		MHL012-137	B. WING		10/0	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PARK PLA	ACE	109 PARK		_		
			TON, NC 28655			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETE DATE
V 366	Continued From page	e 61	V 366			
	staff) said they believe confessed to it. They the Group Home leve	ed me because the kid sent me to the hospital, said led me up and said they l was too aggressive."				
	Interview on 09/23/20 parent/guardian reveal					
	-She did not learn abo	out the 06/02/2021 incident				
	until a week or so after -FC #6 began to act of #7.	er it happened. out aggressively toward FC				
	-She was informed the facility would contact local					
	police about the 06/02 -"I talked to them (loc investigation."	2/2021 incident. al police) and they did an				
	~	they (facility) would remove				
		om the home and separate				
		re not able to do so, and the same home together."				
		rs in [FC #6] increased. He				
	didn't feel safe and di	dn't understand why he had				
		with the other individual				
	[FC #7]." -" I was asked to adm	it him in the hospital to get				
	him out of the house. committed to keep him	[QP] asked me to have him m ([FC #6) from hurting the las triggered because he				
	was placed in the san his adoptive father ab	ne situation he was in when used him. He didn't				
	understand why he had other boy did not."	ad to be removed and the				
		ey would remove the child				
	and they did not remo					
		on 09/21/2021 and 7's DSS guardian were no response to calls or				
	Interview on 09/21/20	21 with the QP revealed:				

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 62 of 79

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		GOWN LETED	
		MHL012-137	B. WING		10/05/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		109 PARKE	R LANE			
PARK PLA	PARK PLACE MORGAI			5		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	E
V 366	Continued From page	e 62	V 366			
V 366	(06/02/2021) happend -"Kids didn't say anythater""Notified [the facility's [Quality Improvement Parents/Guardians, a -She did not recall ex Director or the facility -"[FC #7] told his soci mom about the incide -"[Quality Improvement those kids, then forent she interviewed the s-She (QP) and the Quality Director worked on corestant of the company	cility when the incident ed.  hing until a couple of days  Is NC Program Director],  Director], Police,  Ind state via incident report".  act date she notified QI  Is NC Program Director.  Is worker and his foster  Int Director] had to interview  Is ic interview by police. Then  It tatement. They don't write  Is I do. The staff do level I  IFC#6] expressed he was  Int (FC #6) so we couldn't let  Is I leave FC #7 by himself.  Is on that room at all times.  Is staff and [Managed Care  I laid they would give us one.  I this client at all times  I make sure someone was  I poly2021 for FC #6. Team  I have him admitted to the  I resation between all of us	V 366			
	•	probation office). Mom said o the magistrate office and ted himself. I went to				

Division of Health Service Regulation

STATE FORM 6899 NBPP11 If continuation sheet 63 of 79

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMP	ETED	
		MHL012-137	B. WING		10/0	05/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
		109 PARK	ER LANE				
PARK PLA	ACE	MORGAN	TON, NC 28655	5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
V 366	Continued From page	e 63	V 366				
V 300	magistrate office with #6] said he would hur the facility."  -She (QP) and therap placement for FC #7  -Sent out numerous rone would take him doubt a said of the DSS was initially give for FC #7 on 04/28/20  -After the 06/02/2021  Program Director] tole of Social Services-DS have to come and pict discharge notice got endischarge notice got endischarge notice got endischarge notice got discharge notice got discharge notice got endischarge endicht endischarge endischarge endischarge endischarge endischarge	mom and grandad. He [FC rt that kid if he went back to bist attempted to locate prior to 06/02/2021 incident. referrals for FC #7 and no lue to his behaviors. referrals for FC #7 and no lue to his behaviors. referrals for FC #7 and no lue to his behaviors. referrals for FC #7 and no lue to his behaviors. referrals for FC #7 and no lue to his behaviors. referrals for FC #7 and no lue to his behaviors. referrals for FC #7 and no lue to his behaviors. In control of the following for the following	V 300				
	victim and predator in	peen different. Can't have a n the same house."					
	revealed:	021 with Licensed Therapist  Just gather information.					

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 64 of 79

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
			A. BOILDING.			
		MHL012-137	B. WING			/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
		109 PAR	KER LANE			
PARK PL	ACE		NTON, NC 28655			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETE DATE
V 366	Continued From pag	e 64	V 366			
	(Interview boys, look	at video, obtain				
		ed safety plan) and give to				
	other people."					
	-"I did therapy with the	ne boys [FC #6 and #7],				
	because we could no	•				
		s no place to put them in.				
		ng to the hospital and that				
	helped to resolve that. He then got leveled up to					
PRTF. Even with [FC #7], his DSS agency would not come get him Gave notice, they did not						
	show up. We had to go above their head to get things done. They made complaints about me.  They rewarded his negative behaviors with buying					
		d total disregard for the other				
		ts and just had provocative				
	behaviors. [FC #6]	was able to maintain himself				
	for a little while but e	ended up losing it. [FC #7] did				
	_	ır program at all and [FC #6]				
	came in from Day Pr	ogram but no residential"				
		021 with the facilty's North				
	, , , -	am Director revealed:				
		n June, something occurred				
		n each other rooms. Staff get rvise like they are supposed				
		d corrected. Don't think				
	anything sexual hap					
		se, the facility teaches the				
	clients to call out fire					
	-"The one that made	the allegation kept going				
	back and forth. Once	e that happens, we get				
	<u>-</u>	ctor and QP] are more				
		tigation. I remember being				
	apprised of it."					
		was written up about it or I				
	would have been tole					
		tements and she (QP) was				
	other staff was in the	in kitchen cooking and the				
		06/02/2021 incident was not				

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 65 of 79

Division of Health Service Regulation

DIVISION	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUF	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLET	ΓED
		MHL012-137	B. WING		40/05	/2024
		WIFIL012-137			10/05/	12021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
	ACE.	109 PAR	KER LANE			
PARK PLA	ACE	MORGAI	NTON, NC 2865	5		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RIATE	DATE
				52.16.2.16.7		
V 366	Continued From page	e 65	V 366			
	submitted to Client Ri	ights Committee (CRC) for				
	review.					
	-"It (06/02/2021 incide	ent) should have been				
	submitted. I know eve	erything was reported,				
	probably was an over	sight. Usually present				
	abuse, neglect, and e	exploitation. Client rights				
	usually just give recor	mmendations, sometimes				
	they don't."					
	-"Investigations are ve					
	-Staffed investigation	with QI Director and QP.				
	Had several phone ca	alls about it (06/02/2021				
	incident).					
	-"My kids that come fi	rom a level 3, we know what				
	to expect. If come from	m the community, we don't				
	know their history. We	e had more serious				
		making things more secure.				
	Train the staff better.	Staff not having eyes on is				
	what happened here.					
		scharge was a courtesy.				
		t presentation on what the				
	•	ethical, give a notice, and a				
		xtend it from 60 to 90 days.				
	•	eason I would extend it is if				
		ropriate placement. I am not				
	0 0	kid out in streets, if I don't				
	feel he is safe."					
	Review of Incident ro	port dated 09/12/2021 at				
	11:45 am regarding C					
	-Level 1 incident repo					
	-Consumer Absence					
		talk to his parents and				
		ty. Staff walked around the				
		e client and could not locate				
	him."	silent and oddia not locate				
		ient #2 in company vehicle.				
		playing in the neighborhood				
	creek.	Pictyring in the heighborhood				
	-Staff #1 completed ir	ncident report				
		QP, [Client #2's father], and				

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 66 of 79

Division of Health Service Regulation

Division (	ot Health Service Regu	liation				
STATEMENT	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			7 50.2510			
MHL012-137		B. WING		10/0	5/2021	
			•		<del></del>	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
DARK DI	NOT	109 PARK	ER LANE			
PARK PLA	ACE	MORGAN	TON, NC 2865	5		
()(4) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
V 366	Continued From page	e 66	V 366			
	[Facility's Therapist].					
		reflect 011 cell (police				
		reflect 911 call (police				
	notification).					
	Review on 09/22/202	11 of the 911 recording of		Per agency policy and procedure and APS	SM 30-1	
	09/12/2021 incident r	evealed:		the agency will follow all statutory requiren	nents as	
	-Staff #4 called 911 a	t roughly 2:05 pm.		it relates to reporting of serious incidents.	All Level	
	-Reported Client#2 ha	ad been missing for an hour.		III incidents must be reported within 24 ho		
	-Only 1 Emergency 9	O Dinastan and		QI Director and NC Program Director. The		
	facility on 09/12/2021		Program Manager – QP shall follow i			
	14011119 011 00/ 12/2021	•		reporting to appropriate entities, conducting		
	Interview on 09/15/2021 with Staff #1 revealed:			investigation, obtaining client and staff star		
				At no time will the Lead QP wait more than		
		as monitoring other clients'		hours to report any incidents of a serious r		
	· · · · · · · · · · · · · · · · · · ·	de the facility and also		Reporting requirements shall follow 27G.0 reporting Level II incidents, except deaths,		
	monitoring Client #2 (	(who was outside) through a		occurring during the provision of billable se		10/05/2021
	window.			while the consumer is on the providers pre		
	-"He [Client #2] was t	aking a 5-10 minute timeout		Level III incidents and level II deaths involved		
	_ =	up being an hour. I saw him		clients to whom the provider rendered any	•	
	walk off."	1 3		within 90 days prior to the incident to the L		
		as no longer in his (Staff #1)		responsible for the catchment area where		
		his co-worker (Staff #4)		are provided within 72 hours of becoming	aware of	
		` ,		the incident. If the lead is aware on day 1	then the	
	and then went to look	t for Client #2 in the		lead WILL make the report within 24 hours	or	
	company vehicle.			immediately to all required entities. The		
	· · ·	ing in the creek at the		investigative reports must all be completed		
	bottom of the street.			according to agency and State and Federa		
				requirements. Program director will monito		
	Interview on 09/27/20	021 with Staff #4 revealed:		QP and QI director to ensure that reports a	ire dated.	
	-She was on duty dur	ring the 09/12/2021 incident.				
	-Called the QP and w	vas informed to call 911.				
	-Called 911 to report					
	•	ng for approximately 20				
		1 found and brought him				
	back to the facility.	Tround and brought film				
	1	the tone it was an have"				
	- II I said an nour on t	the tape, it was an hour."				
		021 with the QP revealed:				
	-Client #2 left the pre	mises (9/12/21) and went to				
	the creek down the ro	= =: =: =				
	-After 15 minutes of s	searching for him, staff				
	called the police at he		1			

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 67 of 79

Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED		
		MHL012-137	B. WING		10/05/2021		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
DADKE	ACE.	109 PARK	ER LANE				
PARK PLA	ACE	MORGAN	TON, NC 2865	5			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION (X5)		
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU	JLD BE COMPLE		
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	UPRIATE DATE		
			+	,			
V 366	Continued From page	e 67	V 366				
	-Upon his return, she	instructed staff to call 911 to					
	cancel the call.						
	-The police came to t	he facility and Client #2 was					
	back.						
	-The police did not co	omplete a police report.					
	This deficiency is cro	ss referenced into 10A					
		ope (V179) for a Type A1 rule					
	violation and must be corrected within 23 days.						
		•					
V 367	27G .0604 Incident R	Reporting Requirements	V 367				
	10A NCAC 27G .060	4 INCIDENT					
	REPORTING REQUI						
	CATEGORY A AND E	3 PROVIDERS					
	(a) Category A and E	B providers shall report all					
		ept deaths, that occur during					
	•	le services or while the					
		roviders premises or level III					
		deaths involving the clients rendered any service within					
	90 days prior to the ir						
	responsible for the ca						
	services are provided						
	-	ne incident. The report shall					
	be submitted on a for	· ·					
		rt may be submitted via mail,					
	•	r encrypted electronic					
	· ·	hall include the following					
	information:	ovider contact and					
	(1) reporting pr identification informat						
		fication information;					
	(3) type of incid	•					
	(4) description						
		e effort to determine the					
	cause of the incident;						
	` '	duals or authorities notified					
	or responding.						

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 68 of 79

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL012-137	B. WING		10/0	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PARK PLA	ACE	109 PARKE	R LANE			
MORGAN'		MORGANT	ON, NC 28655	5		
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 367	missing or incomplete shall submit an updat report recipients by the day whenever:  (1) the provider information provided erroneous, misleading (2) the provider required on the incide unavailable.  (c) Category A and B upon request by the Lobtained regarding the (1) hospital recipiformation;  (2) reports by control (3) the provider (4) Category A and B of all level III incident Mental Health, Developments of the provider (5) and 10	providers shall explain any information. The provider ed report to all required the end of the next business. Thas reason to believe that in the report may be gor otherwise unreliable; or obtains information ent form that was previously providers shall submit, and, other information incident, including: ords including confidential of the response to the incident. The providers shall send a copy reports to the Division of opmental Disabilities and	V 367			
	Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).  (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:  (1) medication errors that do not meet the definition of a level II or level III incident;					

Division of Health Service Regulation

STATE FORM 6899 NBPP11 If continuation sheet 69 of 79

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL012-137	B. WING		10/0	5/2021
NAME OF P	PROVIDER OR SUPPLIER	109 PAR	DDRESS, CITY, ST KER LANE NTON, NC 2865			
(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 367	(2) restrictive in the definition of a leve (3) searches of (4) seizures of the possession of a co (5) the total numericidents that occurre (6) a statement been no reportable in incidents have occurred and (d) of this Rull through (4) of this Rull through (4) of this Parameter (a) and (b) of this Parameter (a) and (c) of this Parameter (b) of the criter (a) and (b) of this Parameter (b) of the criter (a) and (b) of this Parameter (b) of the criter (a) and (b) of this Parameter (b) of the criter (c) and (d) of this Parameter (a) and (d) of t	as evidenced by: and record review, the facility argraph.  as evidenced by: and record review, the facility and record review, the facility ent area where services are ours of becoming aware of lings are: pecific details about and 09/17/2021 of Client	V 367	Per agency policy and procedure and 30-1 the agency will follow all statutor requirements as it relates to reporting serious incidents. All Level III inciden be reported within 24 hours to the QI and NC Program Director. The Progr. Manager – QP shall follow instructions reporting to appropriate entities, cond investigation, obtaining client and staf statements. At no time will the Lead 0 more than 24 hours to report any incident a serious nature. Reporting requirem shall follow 27G.0604 for reporting Le incidents, except deaths, that occurrind during the provision of billable service while the consumer is on the provider premises or Level III incidents and level deaths involving the clients to whom to provider rendered any service within Sprior to the incident to the LME responsor to the catchment area where services provided within 72 hours of becoming of the incident. If the lead is aware or then the lead WILL make the report whours or immediately to all required enough the completed according to agency and Spand Federal requirements. Program divill monitor Lead QP and QI director to ensure that reports are dated.	of ts must Director am s for ucting if QP wait dents of ents vel II ng s or s vel II he 90 days nsible s are aware n day 1 nithin 24 ntities.	10/05/2021

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 70 of 79

Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
		MHL012-137	B. WING		10	0/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
PARK PLA	ACE		KER LANE			
240.15	CLIMMADV CT	ATEMENT OF DEFICIENCIES	NTON, NC 28655	PROVIDER'S PLAN OF C	ODDECTION	0.5
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
V 367	Continued From page	<del>2</del> 70	V 367			
	abuse-perpetrator.					
	record revealed: -Admission date of 02 -Discharge date of 07 -Diagnoses of Disrup Disorder (DMDD), Op (ODD), ADHD (Comb Conduct Disorder (Ac violations of rules).  Review on 09/16/202 revealed: -Admission date of 07 -Discharge date of 6/2 -Diagnoses of ADHD, Disorder (dysthymia of (Adolescent-onset typ Review on 09/14/202 facility incident report 09/14/2021 revealed: -Quality Improvement Level III Incident Res (IRIS) report on 06/08 incident regarding FO -The report indicated incident on 06/08/202 Review on 09/17/202 Professional's (QP) h and dated 06/05/202 -She was informed of encounter between F at 07:30 pm on 06/04	tive Mood Dysregulation positional Defiant Disorder pined Presentation) and dolescent onset with serious  1 of FC #7's record  1/29/2021. 30/2021. Persistent Depressive disorder); ODD per Conduct Disorder).  1 and 09/23/2021 of the seriom 06/01/2021 to  1 (QI) Director submitted ponse Improvement System B/2021 for 06/02/2021 co. #7.  The provider learned of the end of the end of the Qualified andwritten statement signed andwritten statement signed to revealed:  I the inappropriate sexual C# 6 and #7 on 06/02/2021 //2021.				
	she (QP) notified other	rence as to who or when ers of the incident.				
	Review of Incident re	port dated 09/12/2021 at				

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 71 of 79

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7.1. 2012510			
		MHL012-137	B. WING		10/05/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
PARK PLA	PARK PLACE 109 PARKE					
		NTON, NC 28655		TION .		
(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 CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE	
V 367	Continued From page	e 71	V 367			
	walked off the proper building to look for the him"Staff searched for Cl -Client #2 was found creekStaff #1 completed ir -Individuals notified; [Facility's Therapist]Document does not notification.	ort completed. (0-3 hours) selected. talk to his parents and ty. Staff walked around the e client and could not locate lient #2 in company vehicle. playing in the neighborhood incident report. QP], [Client #2's father], and reflect Police and/or LME				
	Review on 09/22/2021 of the 911 recording of 09/12/2021 incident revealed: -Staff #4 called 911 at roughly 2:05 pmReported Client#2 had been missing for an hourOnly 1 Emergency 911 call placed from the facility on 09/12/2021.					
	Review on 09/14/2021 and 09/23/2021 of Incident Response Improvement System (IRIS) by county of the facility, name of the facility, and licensee of the facility from 06/01/2021-09/14/2021 revealed: -Level III report entered on 06/08/2021 for 06/02/2021 incident regarding Former Client (FC) #6No report entered in the system for Client #2 regarding the 09/12/2021 incident.  Interview on 09/15/2021 with Staff #1 revealed:					
	complete chores inside monitoring Client #2 (window" He (Client #2) was	as monitoring other clients' de the facility and also (who was outside) through a taking a 5-10 minute t ended up being an hour. I				

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 72 of 79

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		COMILETED
		MHL012-137	B. WING		10/05/2021
NAME OF PROVIDER OR SUPPLIER STREET ADD			RESS, CITY, STA	TE, ZIP CODE	
PARK PLACE 109 PARKE			ER LANE		
I AIRINI LA		MORGANT	ON, NC 28655	5	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 367	Continued From page	e 72	V 367		
	saw him walk off." -Noticed Client #2 wa	s no longer in his (Staff #1) his co-worker (Staff #4) for Client #2 in the			
	Interview on 09/27/2021 with Staff #4 revealed: -She was on duty during the 09/12/2021 incidentCalled the Qualified Professional (QP) and was informed to call 911Called 911 to report Client #2 missingClient #2 was missing for approximately 20 minutes when Staff #1 found and brought him back to the facility.				
	-She wasn't at the fact (06/02/2021) happend "Kids didn't say anythater".  -"Notified [NC Progra Improvement Director Parents/Guardians, a -Could not recall exact (06/02/2021) incident -Client #2 left the predicted the creek down the resulted the police at he -Upon his return, she cancel the call.  -The police came to the back.  -The police did not contain the could be a solution of the call.	m Director], [Quality r], Police, nd state via incident report". ct day she reported the . mises (9/12/21) and went to bad. earching for him, staff er (QP) direction. instructed staff to call 911 to the facility and Client #2 was emplete a police report.			
	Interview on 09/21/2021 with QI Director revealed: -Investigation started Monday (06/07/2021).				

Division of Health Service Regulation

STATE FORM 6899 NBPP11 If continuation sheet 73 of 79

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		
		MHL012-137	B. WING		10/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
PARK PLA	ACE.	109 PARKI	ER LANE		
MORGANT			ON, NC 28655	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 367	Continued From page	e 73	V 367		
	-"Outburst happened maybe she (QP) didn -"Informed [QP] when incident) you need to -"Investigation ended two - can't give you a -Internal investigation This deficiency is cros NCAC 27G.1301 Sco	on Friday (06/04/2021), 't tell me until Monday." n you first learned of it (an tell me". probably within a week or			
V 542	27F .0105(a-c) Client Funds	Rights - Client's Personal	V 542		
	typically provides resiclients for more than a clients for more than above the age of 16 sencouraged to maintapersonal fund account This shall include, but investment of funds in (c) If funds are manaemployee, management in accordance with position of the control of the contr	to any 24-hour facility which idential services to individual 30 days. adult client and each minor shall be assisted and ain or invest his money in a at other than at the facility. It need not be limited to, in interest-bearing accounts. It ged for a client by a facility ent of the funds shall occur olicy and procedures that: the client the right to deposit are receipt and distribution of account; the receipt of deposits made or others; the keeping of adequate all transactions affecting			

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 74 of 79

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		MHL012-137	B. WING	<del></del>	10/0	5/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
PARK PLA	\CF	109 PARK	ER LANE			
TAINIT E	102	MORGAN	TON, NC 2865	5		
(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 542	Continued From page be kept separate from facility;  (6) provide for personal fund accounhabilitation services wor legally responsible to admission of the classification of the classification of the classification of the accounting of his persons depositing of (8) provide the accounting of his persons depositing of (8) provide the accounting of his persons depositing of the accounting of his persons deposition of the accounting of the accounting of the accounting of the accounting to Focus Beh (Licensee), [FC #8] his degree statutory sexus sexually inappropriate accounting to Focus Beh (Licensee), [FC #8] his degree statutory sexus sexually inappropriate.	as evidenced by: e and encouage 1 of 3 audited (#8) to maintain and ersonal fund account. The encouage 1 of 7 audited (#8) to maintain and ersonal fund account. The encouage 1 of 3 audited (#8) to maintain and ersonal fund account. The encouage 1 of 3 audited (#8) to maintain and ersonal fund account. The encouage 1 of 3 audited (#8) to maintain and ersonal fund account. The encouage 1 of 3 audited (#8) to maintain and ersonal fund account. The encouage 1 of 3 audited (#8) to maintain and ersonal fund account. The encouage 1 of 3 audited (#8) to maintain and ersonal fund account. The encouage 1 of 3 audited (#8) to maintain and ersonal fund account. The encouage 1 of 3 audited (#8) to maintain and ersonal fund account. The encouage 1 of 3 audited (#8) to maintain and ersonal fund account. The encouage 1 of 3 audited (#8) to maintain and ersonal fund account. The encouage 1 of 3 audited (#8) to maintain and ersonal fund account. The encouage 1 of 3 audited (#8) to maintain and ersonal fund account. The encouage 1 of 3 audited (#8) to maintain and ersonal fund account. The encouage 1 of 3 audited (#8) to maintain and ersonal fund account. The encouage 1 of 3 audited (#8) to maintain and ersonal fund account. The	V 542		ns ect care ished of client taff in on. and have Training or medical culty in all for em. We taining The und tand ogram care urs this ient	10/28/2021
	result, [FC #8] was pl Offender Registry at t					

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 75 of 79

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
ANDILAN	SI CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMIL	LILD
		MHL012-137	B. WING		10/0	5/2021
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADD			TE, ZIP CODE		
PARK PLA	ACE	109 PARK	ER LANE			
TAINTE		MORGAN	TON, NC 28655	5		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
V 542	Continued From page	e 75	V 542			
	manner and admits the his money, learning to"  -"[FC #8] wants to conside pendent living skew his daily life AEB [as wants and needs i.e. money"  -02/26/2021 - goal rew Monday - Friday; "[FC management skills to and to buy a car[FC the bank every Mondhis money per week, items or tools for work out with staff before to bank account"  -04/26/2021 - goal rew for a place to rent and"  -05/26/2021 - goal reworking full time, look not handling his own car, has car insurance. Interview on 9/21/21 vrevealed:  -FC #8's parent did not talk to surveyors did facility.  -The Qualified Professinto buying a car from \$3,000 - a 2006 Mitsu-FC #8 had numerous.	ith acting in an immature nat he needs help managing to balance wants and needs ills and apply these skills in evidenced by]: Balancing depositing and budgeting viewed - client goes to work C #8] is using his money save money to rent a house C #8] puts his paycheck in ay and only uses \$20.00 of unless he needs personal k[FC #8] always checks it aking any money out of his viewed - "[FC #8] is looking d a car he can afford to buy viewed - "[FC #8] is still king for a place to rent and is money. [FC #8] purchased a e and his permit"  with FC #8's parent  ot feel the FC #8 would want use to his experiences at the sional (QP) talked FC #8 in her granddaughter for				

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 76 of 79

Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION		
			A. BUILDING:			PLETED
		MHL012-137	B. WING		10	/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
PARK PLA	ACE		KER LANE			
		MORGA	NTON, NC 28655			
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 542	Continued From page	e 76	V 542			
	-After FC #8 got his li back and forth from the time. -As far as FC #8's pa	lier- he did not need a car. Icense he (FC #8) drove the facility to work all the rent knew staff was allowed rning to drive (prior to ck).				
	-FC #8 worked Mond carHis mother sold him runFC #8 took the car to where he workedFC #8 needed a car that ran." -Her granddaughter vand was selling her co-she (QP) mentioned granddaughter had a look at itFC #8 test drove the "I let him know she hothing to do with the involved." -FC #8 purchased he This deficiency is crown NCAC 27G.1301 Scott					
V 752	27G .0304(b)(4) Hot	Water Temperatures	V 752			
	EQUIPMENT (b) Safety: Each faci constructed and equi	4 FACILITY DESIGN AND lity shall be designed, pped in a manner that safety of clients, staff and				

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 77 of 79

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRE	CTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		MHL012-137	B. WING		10/0	5/2021
NAME OF PROVIDER	OR SUPPLIER	STREET AD	DRESS, CITY, STA	ITE, ZIP CODE		
DADIK BI AGE		109 PARK	ER LANE			
PARK PLACE		MORGAN'	TON, NC 2865	5		
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
visitors (4) expos water degree  This R Based failed 100-1* are:  Obser approx below followi  -Bathr -Bathr -Bathr -Ritche  Intervi -"I dor -Inform she sa  Intervi -"He to -Water -The le -Bathr stay h -Repo	In areas of ed to hot water shall be maintal es Fahrenheit.  The shall be shall	the facility where clients are, the temperature of the ined between 100-116  as evidenced by: as and interviews, the facility er temperatures between irenheit (°F). The findings  cility on 09/14/2021 between PM-12:50 PM revealed for temperatures in the  PF F CP	V 752	A new water heater was ordered and was delayed. It has been installed and registered at 115 degrees.		10/23/2021

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 78 of 79

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL012-137	B. WING		10	/05/2021
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E, ZIP CODE		
PARK PLA	ACE		KER LANE NTON, NC 28655			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 752	Interview on 09/15/20 -Hot water is cold"I don't like it here." - When hot water is to does not get hotIt (hot water) has been at the programWas told they (the fawater) fixed.  Interview on 09/15/20 - "Hot water is never in the same of the same of the water) goes considered and the water has been of the water has been o	urned up, it (hot water) still en like this since he arrived cility) was getting it (the hot  21 with Staff #2 revealed: too hot." old. re of the low hot water cold for the last couple of  21 with the QP during :	V 752			

Division of Health Service Regulation

STATE FORM NBPP11 If continuation sheet 79 of 79