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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 11/17/21. The complaints were unsubstantiated (intake #NC00181820 and #NC00181997). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. A sister facility is identified in this report. The sister facility will be identified as sister facility A.	V 000		
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	V 109		

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employment system in the State Plan for MH/DD/SAS.
(f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional.
(g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter.

This Rule is not met as evidenced by:
Based on record reviews, observations and interviews, 1 of 6 qualified professionals (QP) (the Licensee) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are:

Cross Reference: G.S. 131E -256 HCPR Prior Employment Verification (V132) Based on record reviews, observations, and interviews, the facility failed to complete an investigation within 5 working days of the initial notification to the Department and failed to put measures in place to protect the clients during the investigation.

Cross Reference: 10A NCAC 27G .1704 Minimum Staffing Requirements (V296) Based on record review and interviews, the facility failed to have two direct care staff present while the clients were awake or asleep affecting 4 of 8 former clients (FC #7, FC #8, FC #10 and FC #12).

Review on 10/28/21 of the Licensee's record

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V 109	Continued From page 2 revealed: - Hire Date: 1/1/01 - Position: Qualified Professional - Based on review of the record, the Licensee has a degree and work history that qualifies her as a Qualified Professional. Review on 11/2/21 of the Plan of Protection dated 11/2/21 written by the Master Level Lead Qualified Professional revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Miracle Houses Inc. Master Level lead Qualified Professional will increase monitoring of the consumers by providing unannounced visits at the facility, increase supervision, training with staff and follow up on all alleged allegations immediately. The Master Level Lead QP will have an open-door policy for all consumers that wants to engage in conversation and meet them as a group. The Master Level Lead QP will monitor QP groups as well. All staff will get prior approval from the Lead QP before exiting the facility and when they return with the consumer via phone or email. Master Level Lead QP will ensure all activities are documented in the communication log. Professional boundaries will continue to be addressed in staff meetings. MHI (Miracle Houses, Inc.) will continue to review the policy for professional boundaries and the Service Definition for Residential Level III to ensure therapeutic relationship. Describe your plans to make sure the above happens. Master Level Lead QP will have an emergency meeting with all staff members at VB1 (Valley Brook 1) on 11/2/21 to roll out the plan of protection for immediately implentation. Master Level Lead QP will communicate on a daily basis with the QP and direct care stafff to ensure plan	V 109		

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of action are being provided. Master Level Lead QP will be more present and active in the facility to ensure therapeutic relationships is provided on a professional level. Immediately take staff off the schedule on all alleged allegations until internal investigations are determined."

Review on 11/17/21 of the Plan of Protection dated 11/16/21 written by the Master Level Lead Qualified Professional revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care? Miracle Houses Inc. Master Level Lead Qualified Professional will increase monitoring of the consumers by providing unannounced visits at the facility, increase supervision, training with staff and follow up on all alleged allegations immediately. Master Level Lead QP will have an open-door policy for all consumers that wants to engage in conversation and continue to meet them as a group. The Master Level Lead QP will monitor QP groups weekly as well. All staff will get prior approval from the Lead QP before exiting the facility and when they return with the consumer via phone or email. Master Level Lead QP will ensure all activities are documented in the communication log. Miracle Houses team will continue to address professional boundaries and code of ethical conduct during monthly staff meetings as well as during scheduled individual supervision according to the staff Supervision Contract. MHI will continue to review the policy for professional boundaries and the Service Definition for Residential Level III to ensure safe therapeutic relationships are maintained. MHI will also ensure monthly in-service trainings are being conducted monthly and that each staff are connecting the dots with consumers served by completing a pre and posttest prior to training, MHI Master Level QP will review in-service

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trainings during monthly staff meetings to ensure staff has a level of understanding of the policy and procedures of abuse, neglect and exploitation. Master level QP will continue to encourage staff members to report immediately alleged allegations to Master Level QP and/or Therapist for internal investigations. The Therapist will also conduct monthly supervision to the Master Level QP, Executive Director and QPs to ensure clinical oversight. Master Level QP, Consumers Right Advocate and Therapist will continue to conduct client specific training during new staff orientation to ensure knowledge of consumers served.
Describe your plans to make sure the above happens.
Master Level Lead QP will have an emergency meeting with all staff members at VB1 on 11/16/21 to roll out the plan of protection for immediately implementation. Master Level Lead QP will communicate on a daily basis with the QP and direct care staff to ensure plan of action are being provided. Master Level Lead QP will be more present and active in the facility to ensure therapeutic relationships is provided on a professional level. Immediately take staff off the schedule on all alleged allegations until internal investigations are determined."

The facility served former clients with various diagnoses not limited to: Attention Deficit Hyperactivity Disorder, Oppositional Disorder and Borderline Intellectual Functioning. The former clients had a history of: conflict with peers, manipulative and defiant behaviors, disrespectful toward staff, verbally aggressive, walking out of the facility without permission, argumentative behaviors, assaultive toward staff, property damage, sexual promiscuity, substance abuse, multiple school suspensions, stealing cars and

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V 109	Continued From page 5 accessory to murder. The Licensee hired FS #9, who was an 18-year-old female, to work in the group home with teenage boys. FC #8 was one year younger than FS #9. At some point FS #9 failed to maintain appropriate staff and client relationship boundaries. FS #9 became pregnant after FC #8 was discharged from the group home. FS #9 has named FC #8 as the father to her unborn child. After leaving the group home, FC #8 had a CFT meeting at his new group home, FC #8 reported that he was going to be a father and the mother was FS #9. The Licensee had been told about the relationship by staff in March 2021, April 2021 and June 2021. In April 2021, when the therapist learned there was some type of ongoing relationship with FS #9 and FC #8, the therapist told the Licensee to fire FS #9. The Licensee continued to allow FS #9 to work in her group homes (to include sister facility A) up until August 2021. The Licensee never did an internal investigation about the inappropriate relationship and never reported any findings to the Health Care Personnel Registry. The level of supervision required of at least 2 staff in the facility was not provided and FS #9 continued to work alone in the group home with the clients. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $5,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 109		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection	V 132		

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G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY
(g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes:
a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.
b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.
c. Misappropriation of the property of a healthcare facility.
d. Diversion of drugs belonging to a health care facility or to a patient or client.
e. Fraud against a health care facility or against a patient or client for whom the employee is providing services).
Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.

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This Rule is not met as evidenced by:
Based on record reviews, observations and interviews, the facility failed to complete an investigation within 5 working days of the initial notification to the Department and failed to put measures in place to protect the clients during the investigation. The findings are:

Interview on 10/25/21 with FS (former staff) #11 revealed:
- FS #9 had become comfortable talking to her soon after FS #9 started working in February or March 2021.
- FS #9 had sent her a text on 6/16/21 with a picture of a positive pregnancy test. In the text FS #9 stated that former client (FC) #8 was the father.
- On 6/22/21, while at the group home, she showed the Licensee the text picture of FS #9's pregnancy test.
- The Licensee asked, "who is that?" and she told her it was FS #9's pregnancy test.
- The Licensee said to her "no way" and she told the Licensee that FS #9 was pregnant with FC #8's child.
- The Licensee asked her how she got that information, and she told the Licensee she talked to FS #9.
- The Licensee told her, "[FS #9] has got to stop working here" and The Licensee further told her, "I am going to report [FS #9] myself."
- The Licensee ended the conversation by telling her to "just delete those messages and don't say

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anything to [FS #9] about it."

Review on 10/25/21 of text messages between FS #9 and FS #11 dated 6/16/21 revealed:
- The first text is a picture of a positive pregnancy test and the following words typed on the picture: "Now this the one I took today."
- FS #11: "So back to you. Who this baby daddy."
- FS #9: "Ughhh you know who."
- FS #11: "[FC #8] can I tell him congratulations."
- FS #9: "If you want to he been funny toward me lately."
- FS #11: "Now he don't need to be doing that. What's been wrong with him."
- FS #9: "Ever since I told him I was pregnant bro Idk (I don't know)."
- FS #11: "He is thinking otherwise on if he's the daddy."
- FS #9: "[FC #8] kno he the d**n daddy he did the s**t yfm (you feel me) he kno I don't f*****g nobody [FC #8] my 2nd body Ian f**k nobody in over 2 years before [FC #8]."

Interview on 10/21/21 with FS #10 revealed:
- During a staff meeting sometime in March 2021, when FC #8 still resided in the group home, she told the Licensee she heard rumors from the other clients that FC #8 and FS #9 had a relationship.
- Then a few weeks later clients reported that FS #9 was in FC #8's bedroom and then there was another meeting.
- "It was like [the Licensee] was having meetings just to gather information but never did anything about it."
- In April 2021, she had a telephone conversation with the group home therapist. She told the therapist she had a conversation with FC #8 and FS #9 about what the clients had been saying regarding the relationship. She further told the

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therapist that neither FC #8 nor FS #9 denied their relationship.
- The therapist told her, she needed to tell the Licensee and did a 3-way call with the Licensee.
- During the April 2021, 3- way call with her, the therapist and the Licensee, she told the Licensee there were rumors from the clients that FC #8 and FS #9 were like "girlfriend and boyfriend" and seemed to like each other. She further told the Licensee she had talked to FS #9 about the relationship and she did not deny it. She also told the Licensee that she talked to FC #8 about the relationship when she took him to work, and FC #8 never denied the relationship and only stated he was the same age as FS #9. During the 3-way call, the Licensee told the therapist that they needed to fire FS #9.

Interview on 10/22/21 with FC #8's Foster Care Social Worker revealed:
- FC #8 was discharged from Miracle Houses Valley Brook I on 3/22/21 and moved to a new group home in another county.
- On 9/7/21, during a treatment team meeting with FC #8 at FC #8's new group home, FC #8 revealed that he was going to be a father and the mother was FS #9.
- FC #8 led her to believe that he had met the mother at his school while he was a client at Miracle Houses Valley Brook I. She never knew that FS #9 was a former staff at Miracle Houses Valley Brook I.

Interview on 10/28/21 with the group home therapist revealed:
- She received a telephone call from FS #10 on 4/29/21 that after FC #8 was discharged, FS #9 and FC #8 "were hanging out together" at FC #9's house.
- She then added the Licensee to the telephone

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call and told the Licensee that she needed to listen to the concerns of FS #10. The same information was conveyed to the Licensee. She could not recall details of the conversation. FS #10 did not state during the call anything sexual had gone on between FS #9 and FC #10.
- After the 4/29/21 3-way call, she talked to the Licensee and said that FS #9 needed to be fired because she broke company policy and had contact with a former client.
- After the 4/29/21 recommendation to fire FS #9, FS #9 continued to work.
- "Everything [FS #10] told me during the telephone message I sent it in my text message to the Licensee and [PRN (fill in) employee/Licensee's son] on 4/28/21. I don't recall anything sexual being brought up."
- "I have worked here since August 2020."
- "I don't like when I make recommendations and it is not adhered to. I make all of my recommendations to [the Licensee]. I make no final decisions here. [The licensee] does not always follow my recommendations."

Review on 10/28/21 of text messages between the group home therapist, the Licensee and a PRN staff (the Licensee's son) revealed:
- The therapist: "[FS #9] was with [FC #8] Friday. [FC #8] showed up at [FS #10's] house at 10 pm with [FS #9] and [FS #10] wouldn't let [FS #9] in."
- PRN staff (the Licensee's son): "We have to show this triggered an internal investigation and we made the proper corrective action."
- The Licensee was on the text messages but did not respond.

Interview on 11/1/21 with the Qualified Professional revealed:
- She is the daughter of the Licensee.
- She first learned about the relationship between

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V 132	Continued From page 11 FC #8 and FS #9 during a July 2021 staff meeting when the Licensee asked staff if they were aware of any former staff who had a relationship with former clients. At that time no one said FC #8 or FS #9's names. - Then in October 2021 a Child Protective Services (CPS) Social Worker called and it came out that allegedly a former employee had a relationship with a former client. Interview on 10/19/21 and 11/2/21 with the Licensee revealed: - She denied after the 3- way call with the therapist and FS #10 that she or the therapist stated anything about firing FS #9. She further stated that she always did what the therapist advised her to do. - She had received a telephone call from CPS social worker on 10/8/21 or 10/9/21. He alleged that FS #9 had a relationship with FC #8 and FS #9 was pregnant with FC #8's child. - She told the CPS social worker that FC #8 was discharged on 3/22/21 and that FS #9's last day was 7/20/21. FS #9's baby is due sometime in February 2022. - She received a text message on 7/20/21 from an unknown number and she never saved the text. From what she could remember, the text stated a staff member was pregnant by a former client. On 11/2/21 she reported the clients' names specifically: "I should have reported that [FS #9] and [FC #8] were having an alleged relationship in July 20, 2021 when I got the text." - In July 2021 after FS #9 called in sick, she contacted FS #9 and asked her if she was having a relationship with FC #8 and she said no. FS #9 told her she was pregnant but would not tell her the name of the father. - After CPS called her around 10/6/21 and said there was an allegation against FS #9, she felt	V 132		

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that CPS knew more than her and she attempted to submit an IRIS report.
- "I felt if I showed that I tried to put it in the system that would be enough."

Review on 10/19/21 of the Incident Response Improvement System (IRIS) revealed:
- There was not an incident report regarding FS #9 and FC #8's relationship.

Review on 10/19/21 of an incident report dated 10/6/21 revealed:
- "Name and Title of Person completing this form: [the Licensee]"
- "Consumer's Name: [FC #8]"
- "Check all that apply": box checked beside of "Sexual abuse/assault/rape"
- "10/8/21 Child Protected Services contacted Executive Director (the Licensee) and informed her of the sexual abuse allegation against a formal employee that resulted in a pregnancy. Based off the due date, the unborn baby was conceived while the consumer and staff were no longer a part of the Miracle Houses, Inc. agency."
- This incident was never submitted to IRIS.

Interview and Observations at approximately 3:00 pm on 10/28/21 with the Licensee revealed:
- FS #9 called her yesterday (10/27/21).
- FS #9 said to her during the telephone call, "remember when you had me to sign your name on a MAR (medication administration review) when I was not supposed to work. [FS #9] said to her, she (the facility compliance consultant) knows about me signing your name. I (the Licensee) said to [FS #9] you have never signed my name. I (the Licensee) said to [FS #9] we have to stick together."
- The Licensee handed over a copy of a paycheck document which indicated FS #9

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	MHL049-155	A. BUILDING: ______ B. WING ______	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRACLE HOUSES VALLEY BROOK I	245 VALLEY BROOK LANE TROUTMAN, NC 28166

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 132	Continued From page 13 worked on 8/29/21 at a sister facility A. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 132		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake and the third may be	V 296		

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V 296	Continued From page 14 asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to have two direct care staff present while the clients were awake or asleep affecting 4 of 8 former clients (FC #7, FC #8, FC #10 and FC #12). The findings are: Review on 10/29/21 of FC #7's record revealed: - Admission date:4/16/21 - Discharge date: 8/13/21 Review on 10/20/21 of FC #8's record revealed: - Admission date:8/10/20 - Discharge date: 3/22/21 Review on 10/29/21 of FC #10's record revealed: - Admission date: 2/23/21 - Discharge date: 4/8/21 Review on 10/29/21 of FC #12's record revealed:	V 296		

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V 296	Continued From page 15	V 296		

- Admission date: 11/2/20
- Discharge date: 5/10/21

Interview on 10/22/21 with FC #10 revealed:
- Former staff (FS) #9 worked alone "all the time" when he lived at Miracle Houses Valley Brook 1.
- FS #9 worked different shifts alone.

Interview on 11/3/21 with FC #7 revealed:
- When he lived in the group home there were either 1 or 2 staff who worked each shift.
- FS #9 had worked alone when he lived at Miracle Houses Valley Brook 1.

Attempted interview on 10/27/21 with FC #8 revealed:
- Attempted to interview client but he ended telephone call.

Interview on 10/26/21 with FC #12's legal guardian revealed:
- She tried to get FC #12 to do an interview and he refused.

Interviews on 10/19/21 and10/28/21 with the Licensee revealed:
- During the summer months (2021), there had been times when there was only one staff who worked in the group home.
- On 10/28/21 she denied FS #9 had ever worked alone at Miracle Houses Valley Brook 1 but indicated FS #9 had worked at a sister facility A alone.
- On 10/19/21, she indicated that if a staff was running late for work and there was no staff at the group home, FS #9 lived close by and FS #9 would go over to the group home and meet the clients who were getting off the bus.

Interview on 10/28/21 with the group home

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therapist revealed:
- Prior to April 2021 she knew there was a lot of times staff called in sick, and there was staff turnover.
- "There were times that staff worked alone. I just don't know if it was a full shift or half shift until they could find someone."

Interview on 10/21/21 with FS #10 revealed:
- She started working as a Direct Care Staff in the group home around October-November 2020 and ended her employment July 2021.
- FS #9 worked alone in the group home. FS #9 primarily worked 3rd shift in the group home.
- FS #9 worked alone at sister facilities as well.

Interview on 10/25/21 with FS #11 revealed:
- She started working as a Direct Care Staff in the group home at the end of December 2020 and ended her employment June 20, 2021.
- She worked with FS #9 on her first day and trained FS #9.
- She trained FS #9 on 1st shift and then FS #9 started working alone 3rd shift.
- FS #9 also worked other shifts alone.
- "We all worked alone a lot because [the Licensee] couldn't keep staff."

Interview on 10/22/21 with FS #12 revealed:
- She started working as a Direct Care Staff in the group home in December 2020 and ended her employment April 2021.
- When FS #9 started working there (March 2021), she worked with someone during training. FS #9 worked some with her on 2nd shift.
- When FS #9 was finished with training, FS #9 started working alone on 3rd shift.

This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified

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V 296	Continued From page 17 Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 296		