STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-162	A. BUILDING: _____ B. WING _____	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL GOD'S CHILDREN OF BURLINGTON	101 RUBY LANE HAW RIVER, NC 27258

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual survey was completed on October 28, 2021. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.	V 000		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.	V 111	RECEIVED DEC 03 2021 DHSR-MH Licensure Sect	

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V 111	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure an assessment was completed prior to the delivery of services affecting three of four current clients (#1, #2 and #3) and one of three former clients (FC #5). The findings are: a. Review on 10/27/21 of client #1's record revealed: -Admission date of 11/19/20. -Diagnoses of Attention Deficit Hyperactivity Disorder and Unspecified Trauma and Stressor related Disorder. -Date of birth was 8/4/06. -No evidence of an admission assessment completed for client #1 prior to the delivery of services. b. Review on 10/27/21 of client #2's record revealed: -No specific date of admission listed. -Diagnoses of Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder and Intermittent Explosive Disorder. -Date of birth was 1/2/04. -No evidence of an admission assessment completed for client #2 prior to the delivery of services. c. Review on 10/27/21 of client #3's record revealed:	V 111	V111- Day Program Manager will complete initial screening at admission .Clinical Team will review CCA and previous assessments prior to admission. QP and LPC will complete any additionalAGC assessments during the 1st 10 days of admission .	11/19/21 ongoing

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V 111	Continued From page 2 -Admission date of 9/9/21. -Diagnoses of Adjustment Disorder with mixed anxiety and depressed mood, Unspecified Impulse Control and Conduct Disorder, Post Traumatic Stress Disorder and Disruptive Mood Dysregulation Disorder. -Date of birth was 11/28/07. -No evidence of an admission assessment completed for client #3 prior to the delivery of services. d. Review on 10/28/21 of FC #5's record revealed: -Admission date of 10/29/20. -Diagnoses of Oppositional Defiant Disorder, Post Traumatic Stress Disorder and Attention Deficit Hyperactivity Disorder. -Date of birth was 12/3/09. -Discharge date of 9/14/21. -No evidence of an admission assessment completed for FC #5 prior to the delivery of services. Interview with the Program Director on 10/28/21 revealed: -She was not responsible for doing the admission assessments for clients at admission. -The Qualified Professional and/or Licensed Professional were responsible for doing the admission assessment when a client is admitted to the group home. -She confirmed the facility failed to complete an admission assessment for clients #1, #2, #3 and FC #5 prior to delivery of services Interview with the Qualified Professional on 10/28/21 revealed: -She would occasionally do the admission assessment for the group home. -The Licensed Professional also did the	V 111		

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V 111	Continued From page 3 admission assessments when clients are admitted to the home. -She was not sure why the admission assessments had not been completed for any of the clients. -She confirmed the facility failed to complete an admission assessment for clients #1, #2, #3 and FC #5 prior to delivery of services Interview with the Director/Licensee on 10/28/21 revealed: -The Qualified Professional was generally responsible for completing the admission assessment when a client is admitted. -The Program Manager was normally at the group home during the day when clients were admitted. -She thought the Program Manager had been doing the admission assessments. -She confirmed the facility failed to complete an admission assessment for clients #1, #2, #3 and FC #5 prior to delivery of services	V 111	V111- Day Program Manager will complete initial screening at admission .Clinical Team will review CCA and previous assessments prior to mission. QP and LPC will complete any additionalAGC assessments during the 1st 10 days of admission .	11/19/21 ongoing
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies;	V 112		

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V 112	Continued From page 4 (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to include staff responsible and have written consent or agreement by the client or responsible party affecting two of three current clients (#2 and #3). The findings are: a. Review on 10/27/21 of client #2's record revealed: -No specific date of admission listed. -Diagnoses of Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder and Intermittent Explosive Disorder. -Date of birth was 1/2/04. -Person Centered Plan (PCP) was dated 7/6/21. -The PCP had no responsible staff and no written consent or agreement by the client or responsible party for the current group home. b. Review on 10/27/21 of client #3's record revealed:	V 112	V112- Day Program Manager will ensure that PCP signature pages are signed at CFT meetings. QP and LPC will ensure that goals PCPs are updated with in the first 30 days of admission and at each CFT meeting .	11/19/21 ongoing

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V 112	Continued From page 5 -Admission date of 9/9/21. -Diagnoses of Adjustment Disorder with mixed anxiety and depressed mood, Unspecified Impulse Control and Conduct Disorder, Post Traumatic Stress Disorder and Disruptive Mood Dysregulation Disorder. -Date of birth was 11/28/07. -The PCP was dated 7/24/21. -The PCP had no responsible staff and no written consent or agreement by the client or responsible party for the current group home. Interview on 10/28/21 with the Program Manager revealed: -Clients #2 and #3 had been living at the group home for more than 30 days. -They attempted to do a Child and Family Team (CFT) meeting with client #2 on September 20, 2021. Client #2 would not participate during that CFT meeting. -They did the CFT meeting again on October 19, 2021 and client #2 did participate this time. -She had no explanation for client #2's PCP not being updated after that CFT meeting to include the current group homes information. -The team had not met to do a CFT meeting to update the PCP for client #3 since she had been living at the group home. -She confirmed the facility failed to include staff responsible and have written consent or agreement by the client or responsible party in the plans for clients #2 and #3. Interview with the Director/Licensee on 10/28/21 revealed: -The entire team is responsible for ensuring the clients PCP's have the required information. -She was not sure why the PCP's for clients #2 and #3 had not been updated. -She confirmed the facility failed to include staff	V 112		

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V 112	Continued From page 6 responsible and have written consent or agreement by the client or responsible party in the plans for clients #2 and #3.	V 112	V113 Day Program manager will ensure that all initial paperwork is completed upon admission . QP will review admission record during 1st 10 days of admission .	
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders;	V 113	AGC will request that all missing information will be completed and in the record prior to the 30day mark. Clinical Director and Owner will review record at 30days. AGC will document all attempts	

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V 113	Continued From page 7 (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure records were complete for one of three current clients (#2). The findings are: Review on 10/27/21 of client #2's record revealed: -No specific date of admission listed. -Diagnoses of Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder and Intermittent Explosive Disorder. -Date of birth was 1/2/04. -There was no identification face sheet which included: name (last, first, middle, maiden); client record number; date of birth; race, gender and marital status; admission date. - Emergency information which included the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician. -A signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician. Interview with the Program Manager on 10/28/21	V 113		

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V 113	Continued From page 8 revealed: -She was responsible for ensuring the required information was placed in the client records at admission. -She had an admission packet for client #2 when she was admitted to the group home. -She thought some of the information from that admission packet was possibly misplaced. -She confirmed the facility failed to ensure client #2's record was complete.	V 113	V114- AGC will document all emergency and diaster plans on a separate log on each shift . AGC Director and QP will provide training on completing the drills and paperwork .	11/19/21
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to conduct fire and disaster drills under conditions that simulate emergencies. The findings are: Review of the facility's fire and disaster drill log on	V 114	RECEIVED DEC 0 3 2021 DHSR-MH Licensure Sect	

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V 114	Continued From page 9 10/27/21 revealed: -10/21/21-1st shift-both drills were done at the same time -10/3/21-3rd shift-both drills were done at the same time -9/21/21-3rd shift-both drills were done at the same time -9/20/21-2nd shift-a fire drill was conducted -9/8/21-1st shift-both drills were done at the same time -8/22/21-3rd shift-both drills were done at the same time -8/13/21-1st shift-both drills were done at the same time -8/6/21-2nd shift-both drills were done at the same time -7/19/21-3rd shift-both drills were done at the same time -7/16/21-1st shift-both drills were done at the same time -7/15/21-2nd shift-a disaster drill was conducted -6/18/21-2nd shift-a disaster drill was conducted -6/12/21-1st shift-both drills were done at the same time -6/1/21-3rd shift-both drills were done at the same time -5/28/21-2nd shift-a fire drill was conducted -5/8/21-1st shift-both drills were done at the same time -5/5/21-3rd shift-both drills were done at the same time -4/29/21-1st shift-both drills were done at the same time -4/22/21-3rd shift-both drills were done at the same time -4/13/21-2nd shift-a fire drill was conducted -3/16/21-1st shift-both drills were done at the same time -3/12/21-3rd shift-both drills were done at the same time	V 114		

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V 114	Continued From page 10 -3/11/21-2nd shift-disaster drill was conducted -2/26/21-2nd shift-a fire drill was conducted -2/10/21-1st shift-both drills were done at the same time -2/8/21-3rd shift-both drills were done at the same time -1/13/21-3rd shift-both drills were done at the same time -1/7/21-2nd shift-a fire drill was conducted -1/5/21-1st shift-both drills were done at the same time -12/12/20-3rd shift-both drills were done at the same time -12/2/20-1st shift-both drills were done at the same time -11/30/20-3rd shift-both drills were done at the same time -11/1/20-1st shift-both drills were done at the same time -10/20/20-2nd shift-both drills were done at the same time -10/9/20-1st shift-both drills were done at the same time -10/5/20-3rd shift-both drills were done at the same time -Staff consistently conducted fire and disaster drills on the same day and at the same time. Interview with client #1 on 10/27/21 revealed: -Staff did fire and disaster drills with them. -She thought they did the fire and disaster drill at the same time. -She thought they did the fire and disaster drills every other month. Interview with client #2 on 10/27/21 revealed: -She lived at the group home since August 2021. -Staff had not conducted any fire and disaster drills with them.	V 114		

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V 114	Continued From page 11 Interview with client #3 on 10/27/21 revealed: -She lived at the group home for about a month. -Staff had not done any fire and disaster drills with them. Interviews on 10/27/21 and 10/28/21 with the Program Manager revealed: -The group home had three separate shifts. -Staff had been doing the fire and disaster drills at the same time. -The group home had several surveys and they were never informed they could not do fire and disaster drills at the same time. -She confirmed staff failed to conduct fire and disaster drills under conditions that simulate emergencies. Interview on 10/28/21 with the Director/Licensee revealed: -She did not realize staff could not conduct the fire and disaster drills with clients at the same time. -She confirmed staff failed to conduct fire and disaster drills under conditions that simulate emergencies.	V 114		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be	V 118		

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V 118	Continued From page 12 administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to keep the MAR current affecting two of three current clients (#2 and #3). The findings are: a. Review on 10/27/21 of client #2's record revealed: -No specific date of admission listed. -Diagnoses of Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder and Intermittent Explosive Disorder. -Date of birth was 1/2/04.	V 118		

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V 118	Continued From page 13 Review of a physician's orders for client #2 on 10/28/21 revealed: -Order dated 9/20/21 for Ortho Tri-Cyclen lo tablets, one tablet daily and Retin-A gel 0.01%, apply pea-size amount of gel to affected area on face every evening. -Order dated 8/6/21 for Fluticasone Spray 50 micrograms (mcg), use one spray in each nostril daily and Quetiapine 200 milligrams (mg), one tablet three times daily. Review on 10/28/21 of a MAR for client #2 revealed: -September 2021-There were blank boxes for the following medications and dates: On 9/25, 9/26 and 9/28 thru 9/30 for the Ortho Tri-Cyclen lo tablets. On 9/30 for the Fluticasone Spray 50 mcg, Retin-A gel 0.01% gel and Quetiapine 200 mg 8pm dose. b. Review on 10/27/21 of client #3's record revealed: -Admission date of 9/9/21. -Diagnoses of Adjustment Disorder with mixed anxiety and depressed mood, Unspecified Impulse Control and Conduct Disorder, Post Traumatic Stress Disorder and Disruptive Mood Dysregulation Disorder. -Date of birth was 11/28/07. Review of a physician's orders for client #3 on 10/28/21 revealed: -Order dated 8/26/21 for Melatonin 5 mg, one tablet at bedtime; Benztropine 1 mg, one tablet at bedtime and Oxcarbazepine 600 mg, one tablet three times daily. Review on 10/28/21 of MAR's for client #3 revealed: -October 2021-There were blank boxes on 10/1	V 118	V118- MAR will be reviewed daily during shift change. During shift change all staff will document completion of shift activites. QP and Program manager will review MAR weekly.	11/19/21 ongoing

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	MHL001-162	A. BUILDING: _____ B. WING _____	10/28/2021

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V 118	Continued From page 14 12pm dose and 10/28 8am dose for the Oxcarbazepine 600 mg. -September 2021-There were blank boxes on 9/30 for Melatonin 5 mg, Benztropine 1 mg and Oxcarbazepine 600 mg 8pm dose. "Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician" Interview with clients #2 and #3 on 10/27/21 revealed: -Staff administered their medications on a daily basis. Interview with the Program Manager on 10/28/21 revealed: -She thought clients were getting their prescribed medications daily. -She thought the MAR's for clients #2 and #3 were blank because staff forgot to put their initials to indicate the medication had been given. -She confirmed staff failed to keep the MAR's current for clients #2 and #3.	V 118		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.	V 736		

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V 736	Continued From page 15 This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure facility grounds were maintained in a safe, clean, attractive and orderly manner. The findings are: Observation on 10/27/21 at approximately 2:10 pm of the facility revealed: -Upstairs area of the home in the hallway outside of the bedrooms-The door that lead to the emergency exit opened approximately five inches wide. -The back yard area of the home-The upper level of the wooden deck outside of the emergency exit door had two rusted nails protruding from the wood. The nails were obstructing the door from opening all the way to the emergency exit upstairs. The wood to the deck was rotted and there were approximately six rusted nails protruding from some of the steps. There were dried pieces of feces on the upper portion of the wooden deck and on the steps. There was a pillow and approximately 20 pieces of trash laying on the ground underneath the wooden deck. There was a metal ladder, grill, wooden table, inoperable tube television, plastic feeder, metal window awning, jump rope and portion of a window frame on the lower portion of the wooden deck. -The yard area near the side of the home-The wood to the ramp was rotted. There were approximately 12 wooden planks underneath the ramp. Interviews with the Program Manager on 10/27/21 and 10/28/21 revealed: -The clients and staff normally don't use the door to the emergency exit upstairs. -She did not know the door to the emergency exit	V 736	V736- Director and Homeowner will complete monthly inspection of the home inside and outside to assess for repairs . AGC has an outside lawnservice that will maintain the grounds for trash removal .	11/19/21 ongoing

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V 736	Continued From page 16 would not open. -She did not know the rusted nails were protruding from the wood outside of the door and preventing the door from opening. -The staff and clients rarely go into the back yard and/or the side of the home. -They did not know the trash and other items were laying on the ground and deck in the backyard. -She thought the feces was on the deck and steps because she had seen cats and dogs go into the backyard. -She confirmed the facility failed to ensure facility grounds were maintained in a safe, clean, attractive and orderly manner. Interview with the Qualified Professional on 10/28/21 revealed: -There was an issue with that door upstairs to the emergency exit not opening just recently. -She could not remember when the door would not open. -She did not realize there was a current issue with the door to the emergency exit. -Staff just notified her yesterday about the door to the emergency exit not opening properly. -Staff and the clients had not said anything to her about the door to the emergency exit not opening. -She confirmed the facility failed to ensure facility grounds were maintained in a safe, clean, attractive and orderly manner. Interview with the Director/Licensee on 10/28/21 revealed: -She did not own the home. She leased the home from someone in the area. -She noticed there was an issue with the emergency egress door about a month or so ago. -There were nails sticking out of the wood outside of the door. The door would not open from the	V 736		

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V 736	Continued From page 17 inside. -She hammered the nails into the wood outside of the door. -She did not realize the nails were sticking up again outside of the door and the emergency exit door would not open. -The clients and staff rarely go into the back yard, she did not realize there was trash and other items in the back yard. -She did not realize the pieces of wood were still underneath the deck on the side of the home. -She thought those pieces of wood had been picked up already. -She confirmed the facility failed to ensure facility grounds were maintained in a safe, clean, attractive and orderly manner. Review on 10/28/21 of a Plan of Protection written by the Program Manager dated 10/28/21 revealed: What immediate action will the facility take to ensure the safety of the consumers in your care: "All God's Children Staff will check the exit door frequently. All God's Children Staff will replace the nails on the back stairway. All God's Children Staff will remove all debris from outside and back porch. All God's Children Staff will communicate with homeowner regarding rotted wood on stairway." Describe your plans to make sure the above happens: "All God's Children Staff will contact homeowner regarding replacing rotted wood. The [Director/Licensee] and homeowner will work together to remove all debris and ongoing maintenance." The facility served clients with diagnoses that included Attention Deficit Hyperactivity Disorder, Unspecified Trauma and Stressor related Disorder, Oppositional Defiant Disorder,	V 736		

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V 736	Continued From page 18 Intermittent Explosive Disorder, Adjustment Disorder with mixed anxiety and depressed mood, Unspecified Impulse Control and Conduct Disorder, Post Traumatic Stress Disorder and Disruptive Mood Dysregulation Disorder. The door to the emergency exit upstairs would not open properly because two rusted nails were protruding from the wood outside of the door. The Qualified Professional and Director/Licensee were aware the door to the emergency exit had not opened properly on other occasions. The deck in the backyard area had rotted wood and other rusted nails protruding from some of the steps. There were pieces of trash on the ground underneath the wooden deck. On the side of the home the wood to the ramp was rotted and there were wooden planks underneath the ramp. This deficiency constitutes a Type A2 rule violation for substantial risk of serious harm and must be corrected within 23 days. An administrative penalty of $500.00 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 736		