			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
		MHL026-689	B. WING		R 12/10/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	-
LUV-N-AF	PMS	6777 CANI	DLEWOOD DR	IVE	
LOV-N-AN	AIVIO	FAYETTEV	ILLE, NC 2831	14	
(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
V 000	INITIAL COMMENTS	:	V 000		
		•			
		d for the following service 27G .1700 Residential re for Children or			
	The survey sample co current clients.	onsisted of audits of three			
V 109	27G .0203 Privileging	g/Training Professionals	V 109		
	QUALIFIED PROFES ASSOCIATE PROFE (a) There shall be no qualified professional (b) Qualified professi professionals shall de and abilities required (c) At such time as a employment system i then qualified profess professionals shall de (d) Competence sha exhibiting core skills i (1) technical knowle (2) cultural awarene (3) analytical skills; (4) decision-making; (5) interpersonal skil (6) communication s (7) clinical skills. (e) Qualified professi NCAC 27G .0104 (18)	ssionals o privileging requirements for is or associate professionals. ionals and associate emonstrate knowledge, skills by the population served. competency-based is established by rulemaking, sionals and associate emonstrate competence. Il be demonstrated by including: dge; ss;			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7. BOILBING.		R
		MHL026-689	B. WING		12/10/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
LUV-N-AF	RMS		DLEWOOD DR		
207 1171		FAYETTEV	ILLE, NC 283		
(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 109	develop and impleme for the initiation of an plan upon hiring each (g) The associate pro	n the State Plan for dy for each facility shall nt policies and procedures individualized supervision associate professional. ofessional shall be fied professional with the the period of time as	V 109		
	one Licensee/Qualifier failed to demonstrate abilities required by the findings are: Cross Reference: G.S. CARE PERSONNEL Based on record reviet facility failed to ensure Personnel Registry (Hallegations against her to put measures in plate.)	as evidenced by: ews and interviews, one of d Professionals (L/QP) the knowledge, skills and he population served. The 6. §131E-256 HEALTH REGISTRY (Tag V132). ews and interviews, the he that the Health Care HCPR) is notified of all health care personnel, failed hace to protect the clients on and failed to investigate			
	Cross Reference: 10A INCIDENT RESPONS CATEGORY A AND B Based on record revie	A NCAC 27G .0603 SE REQUIREMENTS FOR PROVIDERS (Tag V366). Ews and interviews the ment their response to level			

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	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION LAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:		, , ,	E SURVEY PLETED		
			D. MING	P. WING		R
		MHL026-689	B. WING		12	2/10/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		6777 CA	NDLEWOOD DRIVE			
LUV-N-AF	RMS	FAYETTE	EVILLE, NC 28314			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 109	Continued From page	2	V 109			
	CATEGORY A AND E Based on record revie failed to report Level	A NCAC 27G .0604 NG REQUIREMENTS FOR B PROVIDERS (Tag V367). Bew and interview, the facility III incidents as required to gement Entity) within 72				
	record revealed: - Date of hire: 02/02/0	of the L/QP's personnel 01. raining completed 03/04/19.				
	- "What immediate ac ensure the safety of t After the internal inve reporting allegations - "Describe your plan- happens. Create & su documents IRIS (Incid	nd dated 12/08/21 revealed: tion will the facility take to he consumers in your care? stigation the protocol for will be followed." s to make sure the above ubmit (the necessary dent Response) report, HCR (Health Care				
	years old. The clients Attention Deficit Hype Oppositional Defiant and Conduct Disorde #8 had choked him at sink. Client #2 and cli witnessed this incider #8 was involved in an Staff #8 had gotten fr wall in client #2's bed had been made awar between client #2 and	range in age from 13 to 15 have diagnoses to include eractivity Disorder, Disorder, Anxiety Disorder r. Client #1 had alleged staff and bent his back over the ent #3 stated they had at as well. Additionally, staff at other incident with client #2. Sustrated and punched the room. The L/QP stated he e of the abusive incident distaff #8 at the time of the vided only verbal redirection.				

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STATE FORM 6899 7M1Q11 If continuation sheet 3 of 24

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		MHL026-689	B. WING		R 12/10/2021
NAME OF D			DECC CITY CTA	TE 7/D CODE	1 12/10/2021
NAIVIE OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA D LEWOOD DRI		
LUV-N-AR	MS		ILLE, NC 2831		
			1222, 110 200		
(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 APPROPF DEFICIENCY)	BE COMPLETE
V 109	Continued From page	÷ 3	V 109		
	The local Department Worker stated she had 11/23/21 of the above documentation had be above incidents. No significant with the agencies had been not internal investigations the ensuring for the coreview of allegations at L/QP failed to demond decision-making ability necessary steps to procedures, notify relidocument these inciderule violation for seriod corrected within 23 dapenalty of \$2,000 is in corrected within 23 days above the state of t	t of Social Services Social d notified the L/QP on a allegations. No een completed about the specific dates or times had a incidents. No collateral otified of the allegations. No a had been completed nor lients' safety during the as required. The fact the strate the required ties and failed to take the soperly follow policies and evant agencies and ents constitutes a Type A1 hous neglect and must be ays. An administrative mposed. If the violation is not ays, an additional of \$500.00 per day will be of the facility is out of			
V 121	27G .0209 (F) Medica	ation Requirements	V 121		
	governing body or op for obtaining a review regimen at least ever shall be to be perform physician. The on-site the client's physician the review when med	es psychotropic drugs, the erator shall be responsible of each client's drug y six months. The review ned by a pharmacist or e manager shall assure that is informed of the results of ical intervention is indicated. e drug regimen review shall eent record along with			

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STATE FORM 6899 7M1Q11 If continuation sheet 4 of 24

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	RVFY
	OF CORRECTION	IDENTIFICATION NUMBER:	' '	CONSTRUCTION	COMPLE	
			A. BUILDING:		R	
			D MING	D WING		
		MHL026-689	B. WING		12/10	/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		6777 CA	NDLEWOOD DR	IVE		
LUV-N-AR	RMS	FAYETTI	EVILLE, NC 283	14		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON .	(X5)
(X4) ID PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
				DEI IGIENCI)		
V 121	Continued From page	e 4	V 121			
	. 0					
	This Rule is not met	as evidenced by:				
		ews and interview, the				
		m six-month reviews of the				
		nts receiving psychotropic				
	medications, affecting one of three clients (#2).					
	The findings are:	,				
	3					
	Review on 12/06/21 of	of client #2's record				
	revealed:					
	- 13 year old male.					
	- Admission date of 0	1/30/20.				
	_	ıct Disorder, Oppositional				
		ention Deficit Hyperactivity				
	Disorder (ADHD) Cor					
	Disinhibited Social Er					
	- No documented 6 m	nonth drug regimen review.				
	Daview en 10/00/01	of alicent #Ole deiler desce				
	regimen revealed:	of client #2's daily drug				
		eizures) - 500 milligrams				
	(mg) twice daily.	sizures) - 000 miliigrams				
		nigh blood pressure and				
	ADHD) - 1mg one in					
		l) - 5mg as needed at				
	bedtime.	, 0				
	- Concerta (treats AD	HD) - 18mg every morning.				
		ant) - 25mg once daily.				
	,	ychotic) - 60mg twice daily.				
		sonal allergies) - 1 spray in				
	nostril each day.					
	- Proair HFA (treats a	sthma) - use as needed.				
		the Licensee/Qualified				
	Professional stated:					
	- The Registered Nur	se completed drug reviews				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MI II TIDI E	CONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	' '		COMPLETED	
			A. BUILDING: _			
					R	
		MHL026-689	B. WING		12/10/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE		
TO THE OT THE	NOVIDER OR GOLL ELER					
LUV-N-AR	RMS		NDLEWOOD DRI			
			VILLE, NC 2831			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(-/	
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		
		,		DEFICIENCY)		
14404		_	1,404			
V 121	Continued From page	5	V 121			
	on the clients.					
		a physician or pharmacist				
	-	th drug regimen reviews per				
	rule.	arag regimen reviews per				
	Tulo.					
V/ 422	O C 424E 256(C) HC	NDD Notification	V 122			
V 132	G.S. 131E-256(G) HC		V 132			
	Allegations, & Protect	lion				
	O C	LTU CARE DERCONNEL				
	_	LTH CARE PERSONNEL				
	REGISTRY					
	(0)	es shall ensure that the				
		d of all allegations against				
	health care personne	- ·				
		ch appear to be related to				
	-	ivision (a)(1) of this section.				
	(which includes:	of a vacidant in a leadth arm				
	~	of a resident in a healthcare				
		whom home care services				
		31E-136 or hospice services				
	•	31E-201 are being provided.				
		of the property of a resident				
		y, as defined in subsection				
		uding places where home				
		ned by G.S. 131E-136 or				
		lefined by G.S. 131E-201				
	are being provided.	of the property of a				
	 c. Misappropriation of the healthcare facility. 	or the property or a				
	_	a balanging to a bacith care				
	facility or to a patient	s belonging to a health care				
		ealth care facility or against				
	_	whom the employee is				
	providing services).	whom the employee is				
		ovidence that all alleged				
		evidence that all alleged				
		and must make every effort				
	to protect residents from					
	investigation is in pro	gress. The results of all				

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investigations must be reported to the

Department within five working days of the initial

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING		R	
		MHL026-689	B. WING		12/10/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
LUV-N-AR	MS		DLEWOOD DR			
			ILLE, NC 283			
(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 APPROPF DEFICIENCY)	BE COMPLETE	
V 132	Continued From page	e 6	V 132			
	notification to the Dep	partment.				
	·					
	This Rule is not met	as evidenced by:				
		ews and interviews, the				
	•	e that the Health Care HCPR) is notified of all				
		ealth care personnel, failed				
	to put measures in pla	ace to protect the clients				
		on and failed to investigate				
	allegations of abuse.	The findings are:				
		and 12/08/21 of facility				
		ber 2021 thru present				
	revealed no documer #2's allegations of ab	ntation of client #1 and client				
	#2 5 allegations of ab	use against stail #0.				
		and 12/08/21 of client #1's				
	record revealed;					
	13 year old male.Admission date of 0	7/30/21				
		ion Deficit Hyperactivity				
	Disorder (ADHD) Cor	mbined Type, Disruptive				
	Mood Dysregulation [
	Unspecified Anxiety D	Disorder.				
	Review on 12/06/21 a record revealed:	and 12/08/21 of client #2's				

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Division of	of Health Service Regu	liation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					-	,
			B. WING		F	
		MHL026-689	D. WING		12/1	0/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
		6777 CA	NDLEWOOD DR	IVE		
LUV-N-AR	MS		EVILLE, NC 283			
		FATELLI	VILLE, NC 203	14		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
1710		,	17.0	DEFICIENCY)		
V 132	Continued From page	e 7	V 132			
	- 13 year old male.					
	- Admission date of 0	1/30/20				
		uct Disorder, Oppositional				
		D), ADHD Combined Type				
		al Engagement Disorder.				
	and Distillibited Soci	ai Engagement Disorder.				
	Paview on 12/06/21 a	and 12/08/21 of client #3's				
	record revealed:	and 12/00/21 of Client #35				
	- 15 year old male.					
	- Admission date of 0	9/04/21				
	- Diagnoses of Bipola					
	•	Disorder with Psychotic				
	Features.					
	Intonvious on 12/06/21	l and 12/08/21 client #1				
	stated:	rand 12/00/21 Client #1				
		4				
	- He was 13 years old					
		hrough a local county				
	Department of Social	, ,				
	- He recalled an incid					
	between himself and					
	- "He (staff #8) did ch- Staff #8 put his hand					
	•					
		wards the kitchen sink.				
	- His back was agains					
	couldn't talk."	lly squeezed my neck. I				
		arred that moder about 1145				
		ound the neck about "45				
	seconds."					
		facility when the incident				
	occurred.					
	- Client #2 told the Lie					
		out he never told anyone				
	about the incident.					
	Intomico 40/00/04	1 and 40/00/04 altains #0				
		l and 12/08/21 client #2				
	stated:	6 33 6				
		ne facility for one year.				
	- He was currently in					
	 He recalled an incid 	ent between himself and				

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STATEMEN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPLETED		
			B 14/11/0	B. WING			
		MHL026-689	B. WING		12/10/2021		
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STA	TE, ZIP CODE			
LUV-N-AF	ome	6777 CAI	NDLEWOOD DR	IVE			
LUV-IN-AN	AINI S	FAYETTE	VILLE, NC 283	14			
(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 APPROPR DEFICIENCY)	BE COMPLETE	E	
V 132	Continued From page	e 8	V 132				
	staff #8. - He could not remem laying on his bed. - Staff #8 punched a - Staff #8 got mad aft to get cancer from sm - Staff #8 had a family from cancer. - He thought staff #2 #8 punched his wall. - Staff #2 punched the and it was patched. - Staff #8 was also in client #1 in October. - "He (staff #8) choke - Client #1 had splash - Staff #8 grabbed client #8 grabbed client #8 bent client #1 He did not see any in Staff #7 was at the fill.	aber the date but he was hole in his wall. er he told him he was going hoking. y member that recently died was at the facility when staff e wall just above his head wolved with an incident with d [Client #1] out." hed water on clean dishes. ent #1's "neck." #1 back towards the sink.					
	- He recalled an incid staff #8 The incident was in - Client #1 had splash dishes Staff #8 grabbed cliento the sink Staff #8 was frustrational - He had not spoken incident.	d. cility approximately 4 cm a psychiatric hospital. ent between client #1 and October or November 2021. ned water on the clean ent #1 and pushed his head eed with client #1. with anyone about the					

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- He did not see any injuries.

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		MHL026-689	B. WING		R 12/10/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
	140	6777 CAN	DLEWOOD DR	IVE	
LUV-N-AR	(IVI)	FAYETTE	/ILLE, NC 2831	14	
(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 132	Continued From page	9	V 132		
	stated:	Services Social Worker P of client #1 and client #2's			
	in client #2's bedroom - Staff #8 did not pund - The issue with staff happened a couple of - He had not complete with staff #8 He discussed this w months ago He was not aware o staff #8 He had spoken with everyday and no one - The DSS Social Wo an allegation staff #8 - He had not complete notification of applical - Staff #8 was not sus	ry every day. If #8 had "indented" the wall It. It. It. It. It. It. It. I			
	NCAC 27G .0203 CO QUALIFIED PROFES ASSOCIATE PROFE	ss referenced into 10A MPETENCIES OF			
V 366	27G .0603 Incident R	•	V 366		
	10A NCAC 27G .0603	3 INCIDENT			

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DIVISION	n Health Service Negu	ialion	1			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					l _	
			5			₹
		MHL026-689	B. WING		12/1	0/2021
NAME OF D	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE ZID CODE		
NAME OF FI	NOVIDER OR SUFFLIER					
LUV-N-AR	MS		DLEWOOD DR			
20111711		FAYETTE\	ILLE, NC 283	14		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(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	RIATE	DATE
				DEFICIENCY)		
V 366	Continued Frame none	- 10	V 366			
V 300	Continued From page	e 10	V 300			
	RESPONSE REQUIF	REMENTS FOR				
	CATEGORY A AND E					
		B providers shall develop and				
	implement written pol	·				
		or III incidents. The policies				
	•	·				
	shall require the provi					
	` '	the health and safety needs				
	of individuals involved					
		the cause of the incident;				
		and implementing corrective				
	measures according t	to provider specified				
	timeframes not to exc	ceed 45 days;				
	(4) developing	and implementing measures				
	to prevent similar inci	dents according to provider				
	•	not to exceed 45 days;				
	· · · · · · · · · · · · · · · · · · ·	erson(s) to be responsible				
	for implementation of					
	preventive measures;					
		, confidentiality requirements				
		article 2A, 10A NCAC 26B,				
		3 and 45 CFR Parts 160 and				
	164; and					
	` ,	documentation regarding				
) through (a)(6) of this Rule.				
	• •	requirements set forth in				
		Rule, ICF/MR providers				
	shall address incident	ts as required by the federal				
	regulations in 42 CFF	R Part 483 Subpart I.				
		requirements set forth in				
	• ,	Rule, Category A and B				
		CF/MR providers, shall				
		ent written policies governing				
	-	vel III incident that occurs				
	•	delivering a billable service				
		on the provider's premises.				
	-	uire the provider to respond				
	by:					
	• •	securing the client record				
	by:					

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
			_		R
		MHL026-689	B. WING		12/10/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ΓE, ZIP CODE	
LIN/N AF	nac .	6777 CANI	DLEWOOD DRI	VE	
LUV-N-AF	(IVIS	FAYETTEV	ILLE, NC 2831	4	
(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
	(B) making a pl (C) certifying th	e client record;			
	review team; (2) convening a review team within 24 internal review teams who were not involve were not responsible with direct professions services at the time or review team shall confollows: (A) review the confollows: (A) review the confollows: (B) gather othe (C) issue writte	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 f the incident. The internal applete all of the activities as opy of the client record to a causes of the incident dations for minimizing the			
	preliminary findings o LME in whose catchm located and to the LM if different; and (D) issue a final owner within three mo final report shall be se catchment area the pi LME where the client final written report sha identified by the interr include all public docu incident, and shall ma minimizing the occurr all documents needed available within three	fract shall be sent to the nent area the provider is E 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 take recommendations for ence of future incidents. If it for the report are not months of the incident, the ovider an extension of up to			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3)			
		7. 501251110.			R	
		MHL026-689	B. WING		12	2/10/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	-	
	240	6777 CA	NDLEWOOD DRIVI	E		
LUV-N-AF	RMS	FAYETTE	EVILLE, NC 28314			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 366	(3) immediately (A) the LME researea where the service Rule .0604; (B) the LME wild different; (C) the provide for maintaining and utreatment plan, if different provider; (D) the Department (E) the client's applicable; and	y notifying the following: sponsible for the catchment ces are provided pursuant to here the client resides, if er agency with responsibility updating the client's erent from the reporting	V 366			
	facility failed to docur III incidents. The find Refer to V132 regard - Client #1 and client abuse against staff # - The Licensee/Quali aware of staff #8 pun client #2 was in his b client's behavior A local Department Social Worker had no allegation of abuse of #8 on 11/23/21. Review on 12/08/21	ews and interviews the ment their response to level ings are: ling specific incident reports. #2 made allegations of				

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7 50.12510.		R
		MHL026-689	B. WING		12/10/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
LUV-N-AR	MS		DLEWOOD DR		
		FAYETTEV	ILLE, NC 2831	14	
(X4) ID PREFIX TAG			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 13	V 366		
	incident reports for cli allegation of abuse a	ient #1 and client #2's gainst staff #8.			
	Interview on 12/08/21				
	- He went to the facilit	ty every day. ff #8 had "indented the wall"			
	in client #2's bedroom				
	- Staff #8 did not pund				
	 The issue with staff happened a couple of 				
		ed a write up or supervision			
	with staff #8.	. 414411			
	 Staπ #8 nad a sister from cancer. 	that recently passed away			
		aff #8 he could get cancer			
	as well.	40 about wist and walking			
	away if he is upset.	#8 about grief and walking			
		ith staff #8 a couple of			
	months ago.	faliant #4 matting abole d by			
	staff #8.	f client #1 getting choked by			
	- He had spoken with	the clients about issues			
	, ,	brought up getting choked. rker did not tell him about			
	an allegation staff #8				
		ed any incident reports for			
	the allegations.				
	This deficiency is cross referenced into 10A				
	NCAC 27G .0203 CO QUALIFIED PROFES				
	ASSOCIATE PROFE	SSIONALS (V109) for a			
	Type A1 rule violation within 23 days.	and must be corrected			
V 367	27G .0604 Incident R	eporting Requirements	V 367		
	10A NCAC 27G .0604	4 INCIDENT			

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DIVISION	n nealth Service Negu	ialion	_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	<i>'</i>
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					n	
		MALIL DOC COO	B. WING		R	.
		MHL026-689	B: Wilto		12/10/202	1
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		6777 CAN	IDLEWOOD DR	IVF		
LUV-N-AR	MS		VILLE, NC 283°			
			11222, 110 200		1	
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	,	(X5) MPLETE
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP		ATE
				DEFICIENCY)		
14007			1400=			
V 367	Continued From page	e 14	V 367			
	REPORTING REQUI	REMENTS FOR				
	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 in	•				
	responsible for the ca					
	services are provided					
	•					
		ne incident. The report shall				
	be submitted on a for	•				
		t may be submitted via mail,				
		r encrypted electronic				
	information:	hall include the following				
	(1) reporting pr	ovider contact and				
	identification informat	ion;				
	(2) client identif	fication information;				
	(3) type of incid	dent;				
	(4) description	of incident;				
		e effort to determine the				
	cause of the incident;	and				
	(6) other individ	duals or authorities notified				
	or responding.					
		providers shall explain any				
		e information. The provider				
		ed report to all required				
		ne end of the next business				
	day whenever:					
	•	r has reason to believe that				
	information provided					
	-	g or otherwise unreliable; or				
		r obtains information				
		ent form that was previously				
	unavailable.	on tomi that was previously				
		providers shall submit,				
		ME, other information				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER SUPPLIER (X2) MULTIPLE CONSTRUCTION A BUILDING: MHL026-689 STREET ADDRESS, CITY, STATE, ZIP CODE 6777 CANDLEWOOD DRIVE FAYETTEVILLE, NC 28314 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG TAG CONSS-REFERENCED TO THE APPROPRIATE DATE V 367 Continued From page 15 obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response 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, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A
MHL026-689 MHL026-689 B. WING
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6777 CANDLEWOOD DRIVE FAYETTEVILLE, NC 28314 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 15 obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response 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, Developmental Disabilities and Substance Abuse Services within 72 hours of
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6777 CANDLEWOOD DRIVE FAYETTEVILLE, NC 28314 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 15 obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response 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, Developmental Disabilities and Substance Abuse Services within 72 hours of
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LUV-N-ARMS G777 CANDLEWOOD DRIVE FAYETTEVILLE, NC 28314 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 15 obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response 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, Developmental Disabilities and Substance Abuse Services within 72 hours of
LUV-N-ARMS CA4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 367 Continued From page 15 V 367
LUV-N-ARMS FAYETTEVILLE, NC 28314 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 15 obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response 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, Developmental Disabilities and Substance Abuse Services within 72 hours of
X44 ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DATE DEFICIENCY) COMPLETE DATE V 367 Continued From page 15 V 367
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 15 obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response 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, Developmental Disabilities and Substance Abuse Services within 72 hours of
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 15 obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response 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, Developmental Disabilities and Substance Abuse Services within 72 hours of
V 367 Continued From page 15 obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response 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, Developmental Disabilities and Substance Abuse Services within 72 hours of
V 367 Continued From page 15 obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response 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, Developmental Disabilities and Substance Abuse Services within 72 hours of
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obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response 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, Developmental Disabilities and Substance Abuse Services within 72 hours of
 (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response 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, Developmental Disabilities and Substance Abuse Services within 72 hours of
information; (2) reports by other authorities; and (3) the provider's response 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, Developmental Disabilities and Substance Abuse Services within 72 hours of
(2) reports by other authorities; and (3) the provider's response 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, Developmental Disabilities and Substance Abuse Services within 72 hours of
(3) the provider's response 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, Developmental Disabilities and Substance Abuse Services within 72 hours of
(3) the provider's response 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, Developmental Disabilities and Substance Abuse Services within 72 hours of
of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of
Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of
Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of
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 III incident;
(2) restrictive interventions that do not meet
the definition of a level II or level III incident;
(3) searches of a client or his living area;
(4) seizures of client property or property in
the possession of a client;
(5) the total number of level II and level III
incidents that occurred; and
(6) a statement indicating that there have
been no reportable incidents whenever no
incidents have occurred during the quarter that
meet any of the criteria as set forth in Paragraphs
(a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.

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MHL026-689 STREETADDRESS_CITY_STATE_2IP_CODE STATT CANDLEWOOD DRVE FAVETTEVILLE, NC 28314 FAVETTEVILLE, NC 28314 D PROVIDERS PINN OF CORRECTION SECH DEPKIENCY MUST BE PRECEDED BY FAUL RESULATORY ON LSO DEPKIEN MEROMATION) WHERE THE SECH DEPKIENCY MUST BE PRECEDED BY FAUL MEST THIS Rule is not met as evidenced by: Based on record review and interview, the facility failed to report Level III incidents as required to the LME (Local Management Entity) within 72 hours. The findings are: Refer to V132 regarding specific incident reports Client #1 and client #2 made allegations of abuse against staff #8 The Licensee/Qualified professional (L/QP) was aware of staff #8 punching client #2's wall while client #2 was in his bed due to frustration from the clients behavior A local Department of Social Services (DSS) Social Worker had notified the L/QP of the allegation of abuse client #1 made against staff #8 on 11/23/21. Review on 12/08/21 of the North Carolina Incident Response Improvement System (RIS) website from September 2021 thru present revealed no Level III incident reports. Interview on 12/08/21 the L/QP stated: - He went to the facility every day He was told that staff #8 had 'indented the wall' in client #2's bedroom.		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6777 CANDLEWOOD DRIVE FAYETTEVILLE, NC 28314 [XM] D ADDRESS PLAN OF GORGECTION SECUNDARY STATEMENT OF DEFICIENCES OF STALL (XM) D FAYETTEVILLE, NC 28314 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report Level Ill incidents as required to the LME (Local Management Entity) within 72 hours. The findings are: Refer to V132 regarding specific incident reports Client #1 and client #2 made allegations of abuse against staff #8. - The Licensee/Qualified professional (L/QP) was aware of staff #8 punching client #2" wall while client #2 was in his bed due to frustration from the clients behavior A local Department of Social Services (DSS) Social Worker had notified the L/QP of the allegation of abuse client #1 made against staff #8 on 11/29/21. Review on 12/08/21 of the North Carolina Incident Response improvement System (IRIS) website from September 2021 thru present revealed no Level Ill incident reports He was told that staff #8 had "indented the wall" in client #2's bedroom.	ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		COMI LETED
CAN ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CROSS-REFERENCED TO THE APPROPRIATE DAY OF CROSS-REFERENCED TO THE			MHL026-689	B. WING		1
Continued From page 16 V 367	NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	-
CALL			6777 CANI	DLEWOOD DR	IVE	
PREFIX TAG (EACH DEFICIENCY MIST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DATE ONLY This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report Level III incidents as required to the LME (Local Management Entity) within 72 hours. The findings are: Refer to V132 regarding specific incident reports. - Client #1 and client #2 made allegations of abuse against staff #8. - The Licensee/Qualified professional (L/OP) was aware of staff #8 punching client #2's wall while client #2 was in his bed due to frustration from the client's behavior. - A local Department of Social Services (DSS) Social Worker had notified the L/OP of the allegation of abuse client #1 made against staff #8. Review on 12/08/21 of the North Carolina Incident Response Improvement System (IRIS) website from September 2021 in thur present revealed no Level III incident reports. Interview on 12/08/21 the L/OP stated: - He was tool that staff #8 had "indented the wall" in client #2's beforoom.	LUV-N-AR	IMS	FAYETTEV	ILLE, NC 283	14	
This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report Level III incidents as required to the LME (Local Management Entity) within 72 hours. The findings are: Refer to V132 regarding specific incident reports Client #1 and client #2 made allegations of abuse against staff #8 The Licensee/Qualified professional (L/QP) was aware of staff #8 punching client #2's wall while client #2 was in his bed due to frustration from the client's behavior A local Department of Social Services (DSS) Social Worker had notified the L/QP of the allegation of abuse client #1 made against staff #8 on 11/23/21. Review on 12/08/21 of the North Carolina Incident Response Improvement System (IRIS) website from September 2021 thru present revealed no Level III incident reports. Interview on 12/08/21 the L/QP stated: - He went to the facility every day He was told that staff #8 had "indented the wall" in client #2's bedroom.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE COMPLETE
This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report Level III incidents as required to the LME (Local Management Entity) within 72 hours. The findings are: Refer to V132 regarding specific incident reports Client #1 and client #2 made allegations of abuse against staff #8 The Licensee/Qualified professional (L/QP) was aware of staff #8 punching client #2's wall while client #2 was in his bed due to frustration from the client \$2 was in his bed due to frustration from the client \$4 was in his bed due to frustration from the client \$4 was in his bed due to frustration from the client \$4 was in his bed due to frustration from the allegation of abuse client #1 made against staff #8 on \$11/23/21\$. Review on \$12/08/21\$ of the North Carolina Incident Response Improvement System (IRIS) website from September 2021 thru present revealed no Level III incident reports. Interview on \$12/08/21\$ the L/QP stated: - He went to the facility every day He was told that staff #8 had "indented the wall" in client #2's bedroom.	V 367	Continued From page	± 16	V 367		
- Stall #8 did not punch a note in the wall. - The issue with staff #8 damaging the wall happened a couple of months ago. - He had not completed a write up or supervision		This Rule is not met a Based on record reviet failed to report Level I the LME (Local Mana hours. The findings at Refer to V132 regardi - Client #1 and client abuse against staff #8 - The Licensee/Qualif aware of staff #8 punclient #2 was in his beclient's behavior A local Department of Social Worker had no allegation of abuse cli #8 on 11/23/21. Review on 12/08/21 or Response Improvement from September 2021 Level III incident report Interview on 12/08/21 - He went to the faciliti - He was told that start in client #2's bedroom - Staff #8 did not punce - The issue with staff happened a couple of	as evidenced by: ew and interview, the facility Ill incidents as required to gement Entity) within 72 re: ing specific incident reports. #2 made allegations of 3. ied professional (L/QP) was ching client #2's wall while ed due to frustration from the of Social Services (DSS) tified the L/QP of the ient #1 made against staff of the North Carolina Incident ent System (IRIS) website thru present revealed no rts. the L/QP stated: ty every day. ff #8 had "indented the wall" in. ch a hole in the wall. #8 damaging the wall f months ago.			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _			
		MHL026-689	B. WING		12/1	0/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
LUV-N-AR	Me	6777 CANI	DLEWOOD DRI	VE		
LUV-N-AN	INIO	FAYETTEV	ILLE, NC 2831	4		
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 367	Continued From page	e 17	V 367			
	from cancer. - Client #2 had told st as well. - He spoke with staff away if he is upset. - He discussed this w months ago. - He was not aware o staff #8. - He had spoken with everyday and no one - The DSS Social Wo an allegation staff #8 - He had not complete notification of applica This deficiency is cross NCAC 27G .0203 CC QUALIFIED PROFES ASSOCIATE PROFE	ed any incident reports nor ble agencies as required. ss referenced into 10A MPETENCIES OF				
V 512	V 512 27D .0304 Client Rights - Harm, Abuse, Neglect		V 512			
	V 512 27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10 A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and					

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	' '		COMPLETED
			A. BUILDING: _		
			R		
		MHL026-689	B. WING		12/10/2021
NAME OF D	ROVIDER OR SUPPLIER	STDEET AI	DDRESS, CITY, STA	TE ZID CODE	
NAME OF F	NOVIDER OR SUFFLIER				
LUV-N-AF	RMS		NDLEWOOD DR		
		FAYETTE	VILLE, NC 283	14	
(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 512	Continued From page	e 18	V 512		
	aggressive client and	which is permitted by			
		y. The degree of force that			
	is necessary depends	-			
		client (such as age, size			
		ntal health) and the degree			
		splayed by the client. Use of			
		es shall be compliance with			
		AC 27E of this Chapter.			
		an employee of Paragraphs			
	(a) through (d) of this Rule shall be grounds for				
	dismissal of the employee.				
		-,			
	This Rule is not met	as evidenced by:			
	Based on record revie	ews and interviews, one of			
	four audited paraprofe	essional staff (#8) abused			
	two of three clients (#	1 and #2). The findings are:			
	Review on 12/06/21 a	and 12/08/21 of client #1's			
	record revealed;				
	- 13 year old male.				
	- Admission date of 0				
		ion Deficit Hyperactivity			
		mbined Type, Disruptive			
	Mood Dysregulation [
	Unspecified Anxiety D	Disorder.			
	Review on 12/06/21 a	and 12/08/21 of client #2's			
	record revealed:				
	- 13 year old male.				
	- Admission date of 0				
		uct Disorder, Oppositional			
		D), ADHD Combined Type			
	and Disinhibited Soci	al Engagement Disorder.			
	Review on 12/06/21 a	and 12/08/21 of client #3's			
	record revealed:				
	- 15 year old male.				
	- Admission date of 0	8/04/21.			

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Division of	of Health Service Regu	ilation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			B. WING		R	
		MHL026-689	B. WING		12/1	0/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE. ZIP CODE		
		6777 CAN	NDLEWOOD DR	IVE		
LUV-N-AR	MS					
		FATELLE	VILLE, NC 283	14		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	'	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
17.0		,	IAG	DEFICIENCY)		
			+			
V 512	Continued From page	e 19	V 512			
	- Diagnoses of Bipola	ar Disorder, ODD and				
		Disorder with Psychotic				
	Features.	Disorder Will'I Sycholic				
	realules.					
	Paview on 12/06/21	and 12/08/21 of the North				
		sponse Improvement System				
	(IRIS) from September					
		report about client #1 and				
		•				
	#2's allegation of abu	ise against stail #o.				
	Paviou on 12/09/21	of the facility incident report				
		•				
		2021 thru present revealed				
		cuments regarding client #1				
	and #2's allegation of	f abuse against staff #8.				
	Intonvious on 12/06/21	I and 12/08/21 client #1				
	stated:	rand 12/06/21 chent#1				
	- He was 13 years old	4				
		u. through a local county				
	Department of Social					
		, ,				
	 He recalled an incid between himself and 					
	- "He (staff #8) did ch					
	- Staff #8 put his hand					
		wards the kitchen sink.				
	- His back was agains					
		lly squeezed my neck. I				
	couldn't talk."					
		ound the neck about "45				
	seconds."					
		facility when the incident				
	occurred.	(O 1:6 1				
	- Client #2 told the Lie					
		out he never told anyone				
	about the incident.					,
	It	04 1 40/00/04 1: 1: 1/0				,
		21 and 12/08/21 client #2				,
	stated:	6 33 6				,
		ne facility for one year.				,
	- He was currently in	8th grade.				

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Division of	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILANC	O CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		OOM! LETED
					R
		MHL026-689	B. WING		12/10/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		6777 CA	NDLEWOOD DRI	IVE	
LUV-N-AR	:MS	FAYETTE	VILLE, NC 2831	14	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	(- /
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
170		,	IAG	DEFICIENCY)	
V 512	Continued From page	20	V 512		
	 He recalled an incid and staff #8. 	ent with between himself			
		ber the date but he was			
	laying on his bed.	ibor the date but no was			
	- Staff #8 punched a	hole in his wall.			
	- Staff #8 got mad aft	er he told him he was going			
	to get cancer from sm	-			
	·	y that recently died from			
	cancer.	was at the facility when stoff			
	#8 punched his wall.	was at the facility when staff			
	•	e wall just above his head			
	and it was patched.	,			
		volved with an incident with			
	client #1 in October.				
	- "He (staff #8) choke				
	- Client #1 nad splast - Staff #8 grabbed clie	ned water on clean dishes.			
	•	#1 back towards the sink.			
	- He did not see any i				
		acility during the incident.			
	- He told L/QP about	the incidents at the facility.			
	Interview on 12/06/21	client #3 stated:			
	- He was 15 years old				
	- He resided at the fa	cility approximately 4			
	months.				
		om a psychiatric Hospital.			
	 He recalled an incid staff #8. 	ent between client #1 and			
		October or November 2021.			
		ned water on the clean			
	dishes.				
		ent #1 and pushed his head			
	into the sink.				
	- Staff #8 was frustrat				
		with anyone about the			
	incident.				

- He did not recall who the second staff at the facility was during the incident.

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DIVISION	n nealth Service Negu	ilation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					-	,
		MALIL DOC COO	B. WING		F	
		MHL026-689	B. W. C		12/1	0/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		6777 CAN	IDLEWOOD DR	IVE		
LUV-N-AR	RMS					
		FATELLE	VILLE, NC 283	14		T
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5) COMPLETE
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		DATE
170		,	170	DEFICIENCY)		
V 512	Continued From page	e 21	V 512			
	- He did not see any i	injuries				
	- The did flot see ally i	injunes.				
	Interview on 12/06/21	staff #8 stated:				
	- He had worked at th					
	- He was a QP at and					
		aprofessional at this facility.				
		any clients in a restrictive				
	intervention in the pa					
		y staff mistreat or harm the				
	clients.	ad threatened the clients.				
		any clients nor punched a				
	hole in the wall.					
		s say they were going to get				
	him fired.					
	- 2 staff always worke					
		allegations against staff at				
	his previous facility.					
	Interview on 12/06/21					
		the facility for 2 months.				
	- 2 staff worked at the					
		ny staff verbally or physically				
	abuse clients.					
		ny staff treat the clients				
	inappropriately.					
	Interview on 12/10/21					
	- She had worked for					
	approximately 9 years					
	- 2 staff worked at the					
		dent between client #1 and				
		sure of a specific date.				
		ed multiple redirections due				
		ed to complete chores.				
	- Client #1 was beatir	ng items with a clothes				
	hanger.					
	- Staff #8 completed	client #1's chores and				
	attempted to take the					
	- Client #1 had gotter	n in staff #8's personal space				

Division of Health Service Regulation

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	A. BUILDING:					
		MHL026-689	B. WING		R 12/10/2021	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1 12/10/2021	
			DLEWOOD DR			
LUV-N-AF	RMS		ILLE, NC 2831			
(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 512	Continued From page	e 22	V 512			
	and he moved him ou - Client #2 began to g disruptive and she be - She never saw staff clients The clients have sai going to get staff fired - She had not seen st of the clients. Interview on 12/08/21 - He went to the facilit - He was told that sta	the tof the way. Jet involved and be Jegan to work with him. Jet involved and be Jegan to work with him. Jet in the past they were Jet in the past they wall in the pa				
	in client #2's bedroom. - Staff #8 did not punch a hole in the wall. - The issue with staff #8 damaging the wall happened a couple of months ago. - He had not completed a write up or supervision with staff #8. - Staff #8 had a sister that recently passed away from cancer. - Client #2 had told staff #8 he could get cancer					
	away if he is upset. - He discussed this w months ago. - No incident report w required reporting proceed and the report of the was not aware of staff #8. - He had spoken with everyday and no one. - The clients had state staff #8 fired. - 2 staff work per shift. - The Department of \$1.	the clients about issues brought up getting choked. ed they were trying to get at at the facility. Social Services (DSS) tell him about an allegation #1.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7 50.12510		R
		MHL026-689	B. WING		12/10/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
LUV-N-AR	PMS	6777 CANE	DLEWOOD DR	VE	
		FAYETTEV	ILLE, NC 2831	4	
(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 512	Continued From page	23	V 512		
	notification of applica	ed any incident reports or ble agencies. spended for an investigation			
	- "What immediate acensure the safety of the Based on the informal staff member will be in actions. A internal invited conducted." - "Describe your plans."	nd dated 12/08/21 revealed: tion will the facility take to he consumers in your care? tion recently relayed the nterviewed and for alleged			
	years old. The clients ADHD, ODD, Anxiety Disorder. Staff #8 cho back over the sink. Clients witnessed the inciden #8 got frustrated with hole in client #2's become made aware of #2 and staff #8 and hole incidents. No docum completed about the dates or times had be incidents. This deficie rule violation for serio corrected within 23 dapenalty of \$2,000 is in corrected within 23 days and the serior within 23 days and the serior corrected within 24 days and the serior corrected withi	t. On another occasion staff client #2 and punched a froom wall. The L/QP had this incident between client ad provided only verbal mentation had been above incidents. No specific ten identified for the ency constitutes a Type A1 us abuse and must be ays. An administrative mposed. If the violation is not ays, an additional of \$500.00 per day will be the facility is out of			

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