

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-696	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RISING PHOENIX INC	STREET ADDRESS, CITY, STATE, ZIP CODE 603 MONTROSE DRIVE GREENSBORO, NC 27410
---	---

(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	<p>INITIAL COMMENTS</p> <p>An annual survey was completed on January 10, 2022. A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents</p> <p>The survey sample consisted of audits of 3 current clients, 0 former clients, 0 deceased clients.</p>	V 000		
V 296	<p>27G .1704 Residential Tx. Child/Adol - Min. Staffing</p> <p>10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS</p> <p>(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.</p> <p>(b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows:</p> <p>(1) two direct care staff shall be present for one, two, three or four children or adolescents;</p> <p>(2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and</p> <p>(3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents.</p> <p>(c) The minimum number of direct care staff during child or adolescent sleep hours is as follows:</p> <p>(1) two direct care staff shall be present and one shall be awake for one through four children or adolescents;</p> <p>(2) two direct care staff shall be present</p>	V 296		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-696	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RISING PHOENIX INC	STREET ADDRESS, CITY, STATE, ZIP CODE 603 MONTROSE DRIVE GREENSBORO, NC 27410
---	---

(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 296	<p>Continued From page 1</p> <p>and both shall be awake for five through eight children or adolescents; and</p> <p>(3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents.</p> <p>(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.</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure two direct care staff were present affecting 3 of 3 audited clients (#1, #2 and #3). The findings are:</p> <p>Observations on 1/7/22, from 10:00am to 10:30am, at the facility revealed: -At 10:00am, staff #1 and client #1 were present at the facility -Staff #1 called the Executive Director (ED) -At 10:30am, the (ED) arrived at the facility.</p> <p>Review on 1/7/22 of client #1's record revealed: An admission date of 9/29/21 -Diagnoses of Attention Deficit Hyperactivity</p>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-696	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RISING PHOENIX INC	STREET ADDRESS, CITY, STATE, ZIP CODE 603 MONTROSE DRIVE GREENSBORO, NC 27410
---	---

(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 296	<p>Continued From page 2</p> <p>Disorder (ADHD), Combined Type by history, Other Disruptive, Impulse Control and Conduct Disorder, Encounter for Mental Health Services for Perpetrator of non-parental child abuse -Age 18</p> <p>-An assessment dated 9/29/21 noted "needs to successfully complete resident treatment, improve overall mental health symptoms and decrease negative behaviors, was referred by the Department of Juvenile Justice. Is currently in the Detention Center for a sex-specific psychological evaluation relative to his adjudication on one count of sexual battery for sexual harmful behavior against his younger male sibling that reportedly occurred on multiple occasions between 2017 and 2019. He is currently under secure custody (his pleat to three felony counts of Forcible Sexual Offender was dismissed) and he has a felony adjudication on a charge of possession of a stole firearm. His insight appears to be limited, his judgement is poor based on his history of legal involvement, also included an assault against his adoptive father as well as multiple runaways and repeated non-compliance in the home. Has endorsed a loss of appetite and weight loss, denies in engaging in sexually harmful behavior against his brother, past reports of sexualized contact with his younger sister in 2017 (which resulted in a legal charge/diversion agreement)."</p> <p>-A treatment plan dated 9/3/21 noted "will participate in treatment by attending appointments transported by one staff to and from appointments as needed. He will follow all recommendations from his therapist and other professionals providing services. Will learn to verbally identify triggers to his anger and replace his thoughts that produce unwanted behaviors, develop an awareness of his physical and cognitive responses to his behaviors, develop</p>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-696	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RISING PHOENIX INC	STREET ADDRESS, CITY, STATE, ZIP CODE 603 MONTROSE DRIVE GREENSBORO, NC 27410
---	---

(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 296	<p>Continued From page 3</p> <p>coping strategies, will participate in individual and group therapy sessions (to process and heal from past trauma), will identify situations, thoughts and feelings that trigger angry feelings, problem behaviors and in an effort to target those actions for behavior response improvement, will appropriately utilize therapeutic leave by completing two of the following objectives in the next 60 days: follow their guardian rules in the home, no elopement and no legal charges. Will attend his classes, without any interruptions such as school referrals to ISS or OSS school suspensions from 3 to 5 times per year to 1 to 2 times per year, will get a healthy amount of sleep and rest each night and wake up in a timely manner to complete morning hygiene, will go to bed on time, be quiet after lights out, going to sleep or resting quietly throughout the night within 3 prompts."</p> <p>Review on 1/7/22 of client #2's record revealed: -An admission date of 9/1/20 -Diagnoses Conduct Disorder, Disruptive Mood Dysregulation Disorder (DMDD) and ADHD, Combined Type -Age 15 -An assessment dated 9/1/20 noted "has received intensive services and has required multiple acute psychiatric hospitalizations and severe difficulties with defiant, aggressive and destructive behaviors, has a longstanding history of severe mood dysregulation and aggression at home and school settings, was accused of sexually inappropriate behavior towards his younger sister, completed his sexual harm treatment but still needs improvement in judgement and insight. Needs behavioral management to address his continued risky and aggressive behaviors with others." -An updated treatment plan dated 6/10/21 noted</p>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-696	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RISING PHOENIX INC	STREET ADDRESS, CITY, STATE, ZIP CODE 603 MONTROSE DRIVE GREENSBORO, NC 27410
---	---

(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 296	<p>Continued From page 4</p> <p>"will demonstrate greater respect and compliance by following the program rules and the daily milieu schedule, responding to directives, communicating in a calm tone of voice, accepting responsibility for actions and having positive interactions with others 4 out of 7 days per week, will improve relationships with authority figures, will learn and implement healthy ways to manage his anger by appropriate expression of his emotions without yelling, threatening and physical aggression, will increase his tolerance to stressors and annoyances and demonstrate improved peer and staff relations, will participate in recreation therapy activities to improve cognitive, physical, social, emotional, team building, hygiene, sportsmanship and independent living skills with same age peers, will get a healthy amount of sleep and rest each night and wake up in a timely manner to complete morning hygiene, will go to bed on time, be quiet after lights out, going to sleep or resting quietly throughout the night within 3 prompts, will actively participate in family and/or natural support therapy at least once a month which will be ongoing throughout treatment to engage an improved relationship with individual and family therapy, will attend school on a daily basis and follow the expectations and rules in the classroom, will take medication as directed and appropriately seek medical care when necessary, will learn to express his frustration in healthy ways by reducing instances of cursing, yelling and threatening and will verbalize his feelings appropriately and use his coping skills to manage his emotions, will engage in appropriate boundaries and accept responsibility for his actions by refraining from exhibiting manipulative behaviors and embellishing accounts "</p> <p>Review on 1/7/22 of client #3's record revealed:</p>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-696	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RISING PHOENIX INC	STREET ADDRESS, CITY, STATE, ZIP CODE 603 MONTROSE DRIVE GREENSBORO, NC 27410
---	---

(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 296	<p>Continued From page 5</p> <p>-An admission date of 9/28/20</p> <p>-Diagnoses of Post-Traumatic Stress Disorder (PTSD), Unspecified, ADHD, Oppositional Defiant Disorder (ODD) and Other sexual dysfunction not due to substance of known psychological condition</p> <p>-Age 17</p> <p>-An assessment dated 9/28/20 noted "has been charged with breaking and entering and has gotten 6-months of probation, has assaulted a younger consumer, has serious impulsivity, aggression and defiance to those in authority, history of AWOL, exposed to watching pornography at age 8 until now, altercations without being provoked, searched internet sites (pornographic, sex with babies, sites sex with niece and step sister), steals women's undergarments and his behaviors have escalated."</p> <p>-An updated treatment plan dated 12/14/21 noted "will follow instructions with no more than 2 verbal prompts by staying on assigned tasks, following expectations/rules and completing daily chores/regimen, will learn and implement healthy ways to cope with his anger by not exhibiting verbal aggression, physical aggression, communicating threats, fighting or displaying manipulative behaviors, will be transported by one staff to and from appointments as needed, will follow all recommendations from his therapist and other professionals providing services, will utilize appropriate boundaries for his actions by refraining from being in others personal space, touching others without consent, refraining from looking at inappropriate content through any form of media, refraining from inappropriate communication, refraining from exhibiting manipulative behaviors and embellishing accounts."</p>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-696	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RISING PHOENIX INC	STREET ADDRESS, CITY, STATE, ZIP CODE 603 MONTROSE DRIVE GREENSBORO, NC 27410
---	---

(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 296	<p>Continued From page 6</p> <p>Interview on 1/7/22 with client #1 revealed: -Been here at the facility since September 29th, 2021 -"This morning [staff #1] was working alone after [AP] left. I know [ED] is on his way. He is usually her when [AP] leaves ..." -Staff #1 was alone at the facility on 1/7/22 for "a couple of hours" -Had not seen the ED at the facility this morning, "but he was here yesterday with [staff #1] ..."</p> <p>Interview on 1/10/22 with client #2 revealed: -Always 2 staff present at the facility, "except when we leave for school."</p> <p>Interview on 1/10/22 with client #3 revealed: -There were usually 2 staff at all times at the facility -Today (1/10/22) there was only one staff here for about 45 minutes. [ED] took one client to his new college ..." -"Over the summer (2021) for about 2 weeks, there was only one staff with me and another client."</p> <p>Interview on 1/7/22 with staff #1 revealed: -Was aware the client to staff ratio was 1:2 -Third shift worked last night and got the clients ready for school, out the door and left -"This morning (1/7/22) it was me and [Executive Director (ED)]. He came in about 8:30am. He had to run out to the store and is coming back ..." -There were normally 2 staff on every shift. -"[Client #1] was in school until 1/5/22. He is transitioning to college on 1/10/22. Since he is not in school yet, he stays here with me."</p> <p>Interview on 1/10/2022 with the Associate Professional (AP) revealed: -Was responsible for the schedules for the facility</p>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-696	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RISING PHOENIX INC	STREET ADDRESS, CITY, STATE, ZIP CODE 603 MONTROSE DRIVE GREENSBORO, NC 27410
---	---

(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 296	<p>Continued From page 7</p> <p>staff</p> <p>-Was not aware staff #1 was the only staff present with client #1 on 1/7/22</p> <p>-"[Client #1] was transitioning out of [an alternative school] and into a school with college prep classes. That is probably why he was alone with [staff #1] on 1/7/22 ..."</p> <p>Interview on 1/10/2022 with the Qualified Professional (QP) revealed:</p> <p>-Was aware of the client to staff ratio of 1:2</p> <p>-Stated there needed to be 2 staff at all times at the facility</p> <p>-"I think [ED] said it was tough to hire and he does his best to have two staff at all times."</p> <p>-ED was responsible for staff schedules.</p> <p>-Had worked at the facility when staff was not available.</p> <p>-"In the past (worked at the facility to fill in) but not recently. If he (the ED) asks me to work (at the facility, then I would see what I could do (working shifts) ..."</p> <p>Interview on 1/7/22 with the Licensed Professional (LP) revealed:</p> <p>-Was aware of the client to staff ratio of 1:2</p> <p>-"Staffing, for the most part, has been consistent. I know [ED] fills in on shifts if there aren't the required staff to client ratio."</p> <p>-Would discuss the issue with the ED and ask for an update on staffing.</p> <p>Interview on 1/7/22 with the ED revealed:</p> <p>-Was are of the client to staff ratio of 1:2</p> <p>-"One of the staff went out on 1/2/22 due to a medical issue and [staff #1] just returned from her break on 1/4/22. I have just been trying to make it work (two staff on every shift). [Staff #1] usually fills in if people are out. With Covid it has been difficult to hire staff. No one wants to work ..."</p>	V 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-696	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RISING PHOENIX INC	STREET ADDRESS, CITY, STATE, ZIP CODE 603 MONTROSE DRIVE GREENSBORO, NC 27410
---	---

(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