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	MHL049-163	A. BUILDING: ______ B. WING ______	01/05/2022

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MIRACLE HOUSES WINCHESTER I	320 WINCHESTER ROAD TROUTMAN, NC 28166

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and complaint survey was completed on 1/5/2022. The complaint was unsubstantiated (intake #NC184763). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. The survey sample consisted of audits of 1 current client and 1 former client.	V 000		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for	V 109		

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V 109	Continued From page 1 MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record reviews and interviews, 1 of 1 Associate Professionals (the AP) failed to demonstrate knowledge, skill and abilities required by the population served. The findings are: Review on 1/5/2022 of the AP's employee record revealed: - Hire date: 7/23/2020 - Documentation of client specific training on 7/23/2020. Review on 1/5/2022 of FC #2's record revealed: - Admission date: 12/9/2021 - Discharge date: 12/31/2021 - Age: 13 - Diagnoses: Unspecified Depressive Disorder; Post Traumatic Stress Disorder; Attention Deficit Hyperactivity Disorder, predominantly inattentive presentation; Mild Neurocognitive Disorder due to Traumatic Brain Injury; Child Physical Abuse; Child Sexual Abuse; Child Neglect. - An assessment dated 12/6/2021 that revealed a	V 109		

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history of brain injury at age 3, anxiety, depression, self-destructive behaviors, multiple out of home placements in level 3 & 4 facilities, and multiple hospitalizations.
- Documentation of assessment at a local hospital emergency department on 12/26/2021 for "ingestion of substance."

Review on 1/4/2022 of the facility's incident reports revealed:
- After arriving at the Licensee's office on 12/29/2021, FC #2 " ... began to display attention-seeking behaviors by yelling, screaming and attempting to inflict self-harm wounds on her arm. Staff intervened immediately to ensure Consumer# 042041 was not successful with scratching and biting herself ...."
- FC #2 was transported to a behavioral health center for evaluation and stabilization.
- On 12/31/2021, "Miracle houses, Inc. received an email stating that an allegation was made against staff (the AP) leaving consumer (FC #2) unattended in her car and the consumer reportedly took 5-30 Tylenol pills"
- An "Investigation of Alleged Abuse by Employee of Miracle Houses, Inc." dated 1/3/2021 revealed: "Summary of Findings/Recommendations: An investigation by Miracle Houses, Inc. found that [the AP] did not secure her personal medication in her vehicle while transporting consumers. [The Qualified Professional (QP)], conducted interviews with staff on how the consumer (FC #2) was able to get Ibuprofen from her vehicle. [The AP] was removed from [the facility] schedule pending an internal investigation ..."

No interview was completed with FC #2 due to her having been in an inpatient hospital for crisis stabilization.

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Interview on 1/5/2022 with the AP revealed:
- The allegation the facility received on 12/31/2021 was related to an incident that occurred on 12/29/2021 while she was transporting Client #1 and FC #2 to the facility office in her personal vehicle.
- She was the only facility staff providing transportation at the time.
- There were usually two facility staff transporting clients, but she had just wanted to make a quick stop to get food for FC #2 because FC #2 told her she was hungry.
- While the order was being filled, FC #2 said she was going to leave and walked out of the restaurant to go sit in the car.
- Client #1 remained in the restaurant in order to get the food when it was ready.
- She tried to stand at the car where she could supervise both Client #1 and FC #2.
- She did not realize that she had left a bottle of ibuprofen in her glove compartment.
- There had only been 5 tablets in the ibuprofen bottle.
- She thought that FC #3 could only have taken 3 of the tablets.
- Following the incident, she was not allowed to have any further contact with clients and was placed on leave while an investigation was conducted.

Interview on 1/5/2022 with the Qualified Professional (QP) revealed:
- The facility tried to always have two staff transport clients.
- After learning of the incident, an investigation was conducted.
- The AP had reported that she had been on the way to the Licensee office with Client #1 and FC #2, but had stopped to pick up food.
- FC #2 walked out of the restaurant and the AP

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stood outside to stand where she could supervise bot clients.
- The AP had not seen FC #2 take the ibuprofen that was in her (the AP's) personal vehicle.
- The AP was typically "really good," but made an error in judgement on that occasion.
- There had not been any other issues with the AP's job performance.

Interview on 1/5/2022 with the Licensed Professional (LP) revealed:
- The only time he was aware that only one staff transported clients was if the clients were split up between staff.
- He was consulted when there were allegations made against facility staff.
- He was not aware of any previous job performance issues with the AP.

Interview on 1/5/2022 with the ED revealed:
- Facility staff were supposed to ensure that there was nothing unsafe, such as pills, in their personal vehicles if they chose to transport clients in them.
- A facility van was available for facility staff to use.
- Following the 12/29/2021 incident, facility staff had been informed during an emergency meeting that they were not to transport clients in their personal vehicles without prior approval.
- The AP had been placed on leave while the incident was investigated.
- There had not been any prior concerns about the AP's job performance.

V 110 — 27G .0204 Training/Supervision Paraprofessionals — V 110

10A NCAC 27G .0204 COMPETENCIES AND

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V 110	Continued From page 5 SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record reviews and interviews, 1 of 2 audited staff (#1) failed to demonstrate knowledge, skills and abilities required by the population served. The findings are:	V 110		

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Review on 1/5/2022 of staff #1's employee record revealed:
- Hire date: 7/30/2021
- Documentation of client specific training on 12/15/2021.

Review on 1/5/2022 of FC #2's record revealed:
- Admission date: 12/9/2021
- Discharge date: 12/31/2021
- Age: 13
- Diagnoses: Unspecified Depressive Disorder; Post Traumatic Stress Disorder; Attention Deficit Hyperactivity Disorder, predominantly inattentive presentation; Mild Neurocognitive Disorder due to Traumatic Brain Injury; Child Physical Abuse; Child Sexual Abuse; Child Neglect.
- An assessment dated 12/6/2021 that revealed a history of brain injury at age 3, anxiety, depression, self-destructive behaviors, multiple out of home placements in level 3 & 4 facilities, and multiple hospitalizations.
- Documentation of assessment at a local hospital emergency department on 12/26/2021 for "ingestion of substance."

Review on 1/4/2022 of the facility's incident reports revealed:
- "On December 26, 2021 about 7pm, [FC #2] was experiencing a lot of anxiety and stressing about her feelings over missing her family for the holidays, her birthday, and calling [a male peer from a sister facility]. [FC #2] stated that she was very depressed and wanted to talk to a consumer for help her with her depression. Staff informed [FC #2] that [the male peer] is not on her call list. After taking her medication, she grabbed one of her prescription bottles and took the last two pills (Lamotrigine 100 mg) before staff could intervene. Staff questioned [FC #2] about did she just take extra medication and she stated yes and

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staff processed with her and asked her why would she do that for she already had her medication. [FC #2] stated for she was depressed. Executive Director (ED) call MHI (mental health) On Call Nurse and spoke [the nurse]
and she informed Executive Director and [FC #2] that the two pills she took was for anxiety and the worse she could feel is ataxia, skin rash, headache, insomnia, and nausea. [FC #2] informed the nurse that she did not feel any of those side effects for she was fine. Executive Director informed the nurse she will go ahead and get her checked out to be on the safe side. Emergency personnel was called and came to check on Consumer and all vital signs were good..."

No interview was completed with FC #2 due to her having been in an inpatient hospital for crisis stabilization.

Interview on 1/5/2022 with staff #1 revealed:
- ON 12/26/2021, she had been working with Staff #2 at the facility.
- She had been preparing medications for administration in the office while Staff #2 was trying to calm Client #1 down in Client #1's bedroom.
- Staff #1 called for help because Client #1 began hyperventilating.
- She had called "Code Red," placed the medications in an unlocked cabinet in the office and went to Client #1's bedroom to assist.
- FC #2 had initially gone to her bedroom when the Code Red was called.
- FC #2's bedroom was located beside the staff office.
- While she was assisting Staff #2 with Client #1, FC #2 went into the office and grabbed her

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medications.
- When she went back to the office, FC #2's bag of medications was missing.
- FC #2 reported that she had taken her medications.
- FC #2 was evaluated at a local hospital, but her lab work did not show that she had taken the amount of medication that FC #2 reported.
- She should have locked up the medications instead of placing them in an unlocked cabinet.
- She had been placed on leave while facility management investigated the incident and had been reprimanded for the incident.
- She had only worked with FC #2 twice since she started working at the facility two weeks ago.

Interview on 1/5/2022 with staff #2 revealed:
- On 12/26/2021, she had been working with Staff #1 at the facility.
- Client #1 began having a behavior, so she tried to process with her to help her calm down.
- Staff #1 had been in the office preparing medications for administration.
- She called a "Code Red" because she needed assistance with Client #1.
- Client #1 was hyperventilating and acting like she could not breathe.
- While Staff #1 was assisting her with Client #1, FC #2 went into the office and grabbed the medications.
- After Client #1 was calm, it was discovered that FC #2's medications were missing.
- FC #2 told facility staff that she had taken two pills.
- She and Staff #1 called the ED immediately to report the incident.
- FC #2 was transported to the local hospital emergency department for evaluation.
- After the incident, a meeting was held with facility staff to discuss FC #2's incident and

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toxicology results.
- The toxicology report had revealed that FC #2 had not taken the medications she said she had.
- Her shift on 12/26/2021 had been the first time she had worked with FC #2.

Interview on 1/5/2022 with the Qualified Professional (QP) revealed:
- She had learned of the 12/26/2021 incident from the ED after she had returned from taking time off around the Christmas holiday.
- She assisted the ED with the investigation into the incident.
- The investigation revealed that Staff #1 had not properly secured FC #2's medications when she was called to assist Staff #2 with Client #1.
- There had not been any prior concerns with Staff #1's job performance.

Interview on 1/5/2022 with the ED revealed:
- On 12/26/2021, Staff #1 notified her immediately of FC #3 taking her bag of medications when Staff #1 had left the office to assist Staff #2 with Client #1.
- FC #2 engaged in a lot of attention-seeking behaviors.
- FC #2 had been "back and forth" about whether she had taken the medications.
- She consulted with a nurse, told her that it was unlikely that the medication should not harm FC #2 if she had taken it, but they could go ahead and take her to be medically evaluated.
- FC #2 was taken to the emergency department at the local hospital.
- The emergency department physician had informed her that FC #2 had not been suicidal or talked about being suicidal when she was assessed.
- Staff #1 was placed on suspension while an investigation was completed.

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V 110	Continued From page 10 - Staff #1 was a dependable person and had never had any other job performance concerns. - Staff #1 had "moved too quickly" during the incident and failed to secure the medications as she should have.	V 110		
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 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.	V 118		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure the MARs were kept current affecting 1 of 1 current clients (#1) and 1 of 1 audited former clients (FC #2). The findings are:

Review on 1/4/2022 of client #1's record revealed:
- Admission date: 12/6/2021
- Diagnoses: Oppositional Defiant Disorder; Attention Deficit-Hyperactivity Disorder, Combined Type; Major Depressive Disorder, recurrent, mild
- Age: 14
- A physician's order for aripiprazole 5 milligrams (mg), 1 tablet twice daily (BID), dated 11/12/2021.

Review on 1/4/2022 of client #1's MARs dated 12/6/2021 to 1/4/2022 revealed:
- The administration instructions for aripiprazole on the January 2022 MAR were for 1 tablet every day instead of 1 tablet BID as ordered.

Review on 1/5/2022 of FC #2's record revealed:
- Admission date: 12/9/2021
- Discharge date: 12/31/2021
- Age: 13
- Diagnoses: Unspecified Depressive Disorder; Post Traumatic Stress Disorder; Attention Deficit Hyperactivity Disorder, predominantly inattentive presentation; Mild Neurocognitive Disorder due to Traumatic Brain Injury; Child Physical Abuse; Child Sexual Abuse; Child Neglect

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- Physician's orders for loratadine 10mg, 1 tablet every morning, dated 11/8/2021; and guanfacine 2mg, 1 tablet every night at bedtime, dated 11/9/2021.

Review on 1/5/2022 of FC #2's MAR dated 12/9/2021 to 12/31/2021 revealed:
- Loratadine and guanfacine were listed together in the same administration instruction block which made it difficult to determine which medication was administered.
- Guanfacine was also listed in a separate administration instruction block with facilty staff initials that indicated that it was administered at the correct time.

Interview on 1/5/2022 with the Associate Professional (AP) revealed:
- If there were errors on clients' MARs, all staff were supposed to make sure that the office staff and the Qualified Professional (QP) was notified.
- The QP was usually the person who made corrections on the MAR forms.
- She believed that Clients #1 and FC #2's medications had been administered correctly.

Interview on 1/5/2022 with the QP revealed:
- She had not been aware of the errors on Client #1 and FC #2's MARs.
- She believed that Client #1 and FC #2 had not been administered the wrong medication doses.

Interview on 1/5/2022 with the Executive Director (ED) revealed:
- While Client #1's aripiprazole instructions on the January MAR were for once daily, facility staff had signed the MAR indicating that the medication was administered correctly twice daily.
- Facility staff should have corrected FC #2's MAR when they saw the names of two different

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRACLE HOUSES WINCHESTER I	**320 WINCHESTER ROAD TROUTMAN, NC 28166**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 13 medications entered on the administration instructions block on the January MAR. - She had a nurse review MARs, and the nurse had not noticed the errors.	V 118		