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	MHL054-159	A. BUILDING: _____ B. WING _____	10/14/2021

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on October 14, 2021. Six complaints were substantiated (intake #NC 00181636, NC00181399, NC00181225, NC00180625, NC00180522 and NC00179923) and six complaints were unsubstantiated (intake #NC00182055, NC00181426, NC00181300, NC00181261, NC00180530 and NC00180274). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting	V 105	Nova will review the existing policy & procedures regarding orders for use of ESI in comparison to Code of Federal Regulations and will revise as applicable. Responsible Person:(s): The Leadership Committee/ Program Director RECEIVED NOV 15 2021 DHSR-MH Licensure Sect	11-13-21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Kimberly Manning | Kimberly Manning, RN, Program Director | 11/01/2021

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V 105	Continued From page 1 problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

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V 105	Continued From page 2 This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to implement written standards that assured operational and programmatic performance meeting applicable standards of practice for restraint and seclusion orders. The findings are: Review on 09/01/21 of the Code of Federal Regulations (CFR) revealed: - "§483.358(d) If the order for restraint or seclusion is verbal, the verbal order must be received by a registered nurse or other licensed staff such as a licensed practical nurse, while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends. The physician or other licensed practioner permitted by the state and the facility to order restraint or seclusion must verify the verbal order in a signed form in the resident's record...." - "§483.358(e) Each Order for restraint or seclusion must: (1) Be limited to no longer than the duration of the emergency safety situation..." Finding #1: Review on 10/11/21 of client #7's record revealed: - 13 year old male. - Admission date of: 11/19/19. - Diagnoses of Disruptive Mood Dysregulation Disorder (DMDD), Conduct Disorder, Post Traumatic Stress Disorder (PTSD), Attention Deficit Hyperactivity Disorder (ADHD)-Combined Type and Oppositional Defiant Disorder (ODD).	V 105		

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V 105	Continued From page 3 A. Review on 10/12/21 of a 04/22/21 "Order for Emergency Safety Interventions" for client #7 revealed: - Date and time of seclusion 04/22/21 at 3:20pm. - Telephone order signed by Registered Nurse (RN) #1. - Seclusion was used from 3:20pm until 3:24pm (4 minutes). - No signature of the physician who ordered the seclusion to verify the verbal order dated 04/22/21 at 3:20pm. Review on 10/12/21 of a 04/16/21 "Order for Emergency Safety Interventions" for client #7 revealed: - Date and time of physical restraint 04/16/21 at 2:30pm. - Telephone order signed by RN #3. - The physical restraint lasted from 2:30pm until 2:35 (5 minutes). - No signature of the physician who ordered the physical restraint to verify the verbal order dated 04/16/21 at 2:30pm. B. Review on 10/12/21 of a 03/30/21 "Order for Emergency Safety Inventions" for client #7 revealed: - A signed physician order for 03/30/21 at 4:35pm and expired at 5:35pm for a duration of one hour. - Date and time seclusion 4:35pm until 4:37pm and 4:38pm until 5:32pm. - No additional order for the seclusion which began at 4:38pm and ended at 5:32pm as required. Review on 10/12/21 of a "Seclusion Tracking Form" for client #7 dated 03/30/21 revealed: - Start time 4:35pm until 4:37pm and 4:38pm until 5:32pm. - Monitoring client #7 documented every 10	V 105		

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V 105	Continued From page 4 minutes from 4:35pm until 5:32pm. Finding #2: Review on 10/12/21 of client #13's record revealed: - 11 year old male. - Admission date of 06/19/20. - Diagnoses of PTSD, ADHD-Combined Type and DMDD. Review on 10/12/21 of a "Order for Emergency Safety Interventions" for client #13 revealed: - A signed physician order for 10/04/21 at 7:32pm and expired 8:32pm. - Date and time of seclusion 7:32pm until 7:48pm and 7:52pm until 8:08pm. - No additional order for the seclusion which began at 7:52pm until 8:08pm as required. Review on 10/12/21 of the "Seclusion Tracking Form" for client #13 dated 104/21 revealed: - Seclusion initiated at 7:32pm and "(seclusion ended)" at 7:48pm. - "(Seclusion reinitiated) #2 episode" at 7:52pm and "(seclusion ended)" at 8:08pm. Review on 10/12/21 of client #13's "Medical Progress Notes" dated 10/04/21 revealed: - At 7:48pm client #13 was given an as needed medication. - At 7:50pm client #13 took his night time medications and was escorted by staff back to his room. - No additional information noted for client #13 seclusion beginning at 7:52pm. Finding #3: Review on 10/8/21 and 10/12/21 of Former Client (FC) #18's record revealed: - 11 year old male.	V 105		

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V 105	Continued From page 5 - Admission date of 12/22/20. - Diagnoses of DMDD, Unspecified Trauma Stressor Related Disorder and Specific learning disorder w/ impairment reading/math. Review on 10/12/21 of a 7/13/21 "Order for Emergency Safety Interventions" for client FC #18 revealed: - Date and time of restraint and seclusion 7/13/21 at 5:48pm. - A signed physician order for 7/13/21 at 5:48pm and expired at 6:48pm for a duration of one hour. - Restraint was used from 5:48pm until 5:49 (1 minute); Seclusion was used from 5:50pm until 5:51pm (1 minute) and Restraint was used 5:51pm until 6:01pm. - No order for the seclusion which began at 5:50pm to 5:51pm or the restraint which began 5:51pm to 6:01pm. Review on 10/12/21 of a 7/1/13 "Order for Emergency Safety Interventions" for FC #18 revealed: - Date and time of restraint 7/1/13 at 3:40pm. - A signed physician order for 7/1/21 at 3:40 and expired at 4:40pm for a duration of one hour. - Restraint was used from 3:40pm until 3:42pm and 3:43pm until 3:47pm. - No order for the restraint which began at 3:43pm to 3:47pm. Finding #3 Review between 10/11/21 - 10/14/21 of FC #21's record revealed: - 12 year old male. - Admission date of 5/10/21. - Discharge date of 9/1/21. - Diagnoses of ADHD-Combined Type and Conduct Disorder Childhood Onset.	V 105		

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V 105	Continued From page 6 A. Review on 10/12/21 of a 6/22/21 "Order for Emergency Safety Interventions" for FC #21 revealed: - Date and time of physical restraint 6/22/21 at 2:25pm. - Telephone order signed by RN #3. - The physical restraint lasted from 2:25pm until 2:32pm (7 minutes). - No signature of the physician who ordered the physical restraint to verify the verbal order dated 6/22/21 at 2:25pm. Review on 10/12/21 of a 8/6/21 "Order for Emergency Safety Interventions" for FC #21 revealed: - Date and time of physical restraint 8/6/21 at 5:14pm. - Verbal order signed by RN (signature unidentified). - The physical restraint lasted from 4:14pm unit 4:21pm (7 minutes). - No signature of the physician who ordered the physical restraint to verify the verbal order dated 8/6/21 at 4:14pm. Review on 10/12/21 of a 8/9/21 "Order for Emergency Safety Interventions" for FC #21 revealed: - Date and time of seclusion 8/9/21 at 5:58pm. - Telephone order signed by RN #4. - The seclusion lasted from 5:58pm until 6:26pm. (28 minutes) - No signature of the physician who ordered the seclusion to verify verbal order dated 8/9/21 at 5:58pm. B. Review on 10/11/21 of a 5/22/21 "Order for Emergency Safety Interventions" for client FC #21 revealed: - Date and time of restraint 5/22/21 at 6:15pm.	V 105		

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V 105	Continued From page 7 - A signed physician order for 5/22/21 at 6:15pm and expired at 7:15pm for a duration of one hour. - Restraint was used from 6:15pm until 6:25pm (10 minutes) and restraint was used 6:35pm until 6:41pm (6 minutes). - No order for the restraint which began at 6:35pm to 6:41pm. Review on 10/11/21 of a 8/15/21 "Order for Emergency Safety Interventions" for FC #21 revealed: - Date and time of restraint and seclusion 8/15/21 at 5:22pm. - A signed physician order for 8/15/21 at 5:22pm and expired at 6:22pm for a duration of one hour. - Seclusion was used from 5:22pm until 5:26pm (4 minutes, seclusion broken for self harm behaviors), restraint was used from 5:26pm until 5:34pm (8 minutes) and restraint was used from 5:36pm until 5:44pm (8 minutes). - No order for the restraint which began at 5:36pm to 5:44pm. Review on 10/12/21 of a "Seclusion Tracking Form" for FC #21 dated 8/15/21 revealed: - Start time 5:22pm until 5:26pm. - "Unacceptable behavior continues... seclusion immediately discontinued headbanged." Interview on 10/12/21 RN #1 stated: - She had been the Director of Nursing for almost one year. - Orders had usually been for one hour for seclusion or restraint. - The facility had used one 1 hour order for multiple seclusions or restraints if the client had deescalated and repeated the same behavior within the ordered time frame. - A different order had to be obtained once the seclusion door opened.	V 105		

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V 105	Continued From page 8 Interview on 10/08/21 the Program Director stated: - The orders for client #7 on 04/16/21 and 04/22/21 had been attached to the restrictive intervention detail report and was not in the medical record for physician signature. - If a physician order had not expired and the original seclusion or restraint ended, then a new order for seclusion or restraint was not needed to begin a new restrictive intervention. - The facility had forms designed specially for the rule. - The interpretive guidelines may indicate a new order must be obtained for each episode of a seclusion or restraint. - There was no rule which required a new order for a seclusion or restraint if it was instituted within the specified time frame of the original order. This deficiency has been cited 7 times since the original cite on August 14, 2018 and must be corrected within 30 days.	V 105		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of	V 367	The facility completed the IRIS reports for the two incidents upon notification and request by DHSR based on their opinion of the level of incident. This was corrected on the date of 10/12/21. The facility will continue to submit incidents as per IRIS Manual instructions within stated time frames. Responsible Person: Program Director	11-13-21

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V 367	Continued From page 9 becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information 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 providers shall send a copy of all level III	V 367		

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V 367	Continued From page 10 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 II or 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. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to report a critical incident to the home and host Local Management Entity (LME)	V 367		

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V 367	Continued From page 11 within 72 hours as required. The findings are: Review on 10/14/21 of a North Carolina Incident Response Improvement System (IRIS) report for client #14 revealed: - Date of Incident: 08/10/21. - Time of Incident: Unknown. - "Consumer Behavior Information" identified "Inappropriate Sexual Behavior". - Provider Comments: "consumer (#14) stated on 8/10/21 he willingly "had sex" with male peer and does not have other details to share. No date of incident and no time of incident and no location of incident. Denies unwanted touching, kissing, etc." - "Describe the cause of this incident, (the details of what led to this incident). Provider 10/12/2021 sexual desire." - "Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. Provider 10/12/2021 encourage consumer to refrain from sexual activity and explain dangers of such behavior." - Date IRIS report was submitted to the LME 10/12/21. Review on 10/14/21 of a North Carolina IRIS report for Former Client (FC) #19 revealed: - Date of Incident: 08/10/21. - Time of Incident: Unknown. - "Consumer Behavior Information" identified "Inappropriate Sexual Behavior." - Provider Comments: Provider 10/12/2021 "consumer (FC #18) states he willingly "had sex with peer" and does not have other details to share. No date of incident and no time of incident and no location of incident. Denies unwanted touching, kissing, etc. - "Describe the cause of this incident, (the details	V 367		

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V 367	Continued From page 12 of what led to this incident). Provider 10/12/2021 sexual desire." - "Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. Provider 10/12/2021 encourage consumer to refrain from sexual activity and explain dangers of such behavior." - Date IRIS report was submitted to the LME 10/12/21. Interview on 10/12/21 and 10/14/21 the Program Director stated: - The facility had considered the sexual allegations with client #14 and FC #19 to be a level I incident report. - The facility had completed level I incident reports dated 08/10/21. - She had spoken with a North Carolina Department of Health and Human Services (DHHS) representative regarding the alleged incident on 08/10/21 between client #14 and FC #19. - FC #19 was moved to another facility. - The therapist had spoken with client #14 and FC #19 and the information on the incident was documented. - The clients were separated and it was never determined if anything happened between them. - She was in the process of completing an IRIS report. - She was unsure why the deficiency was cited since these were the only two reports that were identified as being submitted late. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 367		

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(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 510	Continued From page 13	V 510	NOVA will develop a policy and procedure for client self-governance groups.	12-13-21
V 510	27D .0302 Client Rights - Client Self-Governance 10A NCAC 27D .0302 CLIENT SELF-GOVERNANCE In a day/night or 24-hour facility, the governing body shall develop and implement policy which allows client input into facility governance and the development of client self-governance groups. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement a policy which allows client input into facility governance and the development of client self-governance groups. The findings are: Review on 10/07/21 of the facility policy and procedures revealed no policy which allows for the development of self-governance groups. Interview on 10/14/21 the Program Director stated: - The facility did not have a current policy on the development of self-governance groups. - She indicated she would follow up on the policy and procedure to satisfy the rule area.	V 510	Responsible Person: Clinical Director	
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.	V 736	Maintenace / Repairs will be conducted as follows: in Unit 1 Pod A: >peeling paint and rust spots will be corrected/ removed In Unit 1 Pod B: >the blown light will be replaced In Seclusion Room W7: >dust and scuff marks will be removed from walls. In Unit 2 Pod A: >the light fixture cover will be replaced in sitting area In Unit 2 Pod B: >the dented door will be assessed for repair > the rusty screw will be replaced on the love seat. >Bedroom 1 will have the ceiling dusted. >The patched areas in the bathroom will be painted.	11-13-21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-159	A. BUILDING: _____ B. WING _____	10/14/2021

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V 736	Continued From page 14 This Rule is not met as evidenced by: Based on observation and interviews, the facility was not maintained in a safe, clean attractive and orderly manner. The findings are: Observation of the facility on 10/7/21 at approximately 12:40pm revealed: -Bathroom in Unit 1 Pod A had paint peeling above the shower and rust spots on both ceiling vents. -Unit 1 Pod B had a light blown in the ceiling light fixture in the living area. -Seclusion Room W7 ceiling vent had heavy dust and scuff marks on the walls. -Unit 2 Pod A light fixture cover was missing in sitting area. -Unit 2 Pod B had a dent in the closet door consistent with the entrance door knob; Love seat had a slanted wood backboard with a rusty screw exposed; Bedroom B1 had heavy dust on the ceiling vent; Bathroom had a wood board behind the door partially painted and an approximately 10 inch white unfinished plastered area on the wall. The sitting area had 2 fixture covers missing with exposed light bulbs, 2 of 3 bulbs were blown in 1 light fixture. -Seclusion room X3 had the entire door frame partially separated; dead bugs on the floor. -Seclusion room X4 had the entire door frame partially separated and scuff marks on the door. -Unit 3 Pod A had a rusty ceiling vent in the hallway; dead bugs on floor in living area; unidentified white substances stuck to the ceiling above shower and in the living area. -Unit 3 Pod B had one of two lights which worked in the living room area. The bathroom had paper peeling off the ceiling above the shower area. B1 room had 2 approximately baseball sized white	V 736	> the light fixture covers will be replaced in the sitting area > Blown light bulbs will be replaced. In seclusion rooms X3, X4: >the door frames will be scheduled for repair with an external vendor. >floors will be cleaned, scuff marks will be removed from door. In Unit 3 Pod A: >rusty ceiling vent will be painted or replaced. >floor will be cleaned >ceiling will be cleaned in living and shower area. In Unit 3 Pod B: >the blown light will be replaced >the bathroom ceiling will be repaired above shower >the patched area in B1 will be painted Weekly Facility inspections will be conducted to address similar findings for immediate correction/repairs. Responsible Person(s): Maintenance Manager, Facility Support Coordinator, Housekeeping	

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V 736	Continued From page 15 patched areas on the wall. Interview on 10/7/21 the Maintenance Supervisor stated: -He made a request for light fixture covers and planned to replace the covers, there were several missing light fixture covers. -Clients had kicked the seclusion room doors X3 and X4 resulting in them separating from the door frame. -The facility had contracted with a local company to complete the repairs and had been waiting on the company to start the repairs to seclusion room X3 and X4. Interview on 10/14/21 the Program Director stated she had no questions regarding facility items discussed at exit of the survey. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		