Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL026-689 12/10/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6777 CANDLEWOOD DRIVE** LUV-N-ARMS **FAYETTEVILLE, NC 28314** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 An annual, complaint and follow up survey was completed on December 10, 2021. The complaint was substantiated (intake #NC00183677). 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 three current clients. V 109 27G .0203 Privileging/Training Professionals V 109 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: DHSR - Mental Health (3) analytical skills: (4) decision-making; (5) interpersonal skills; FFB 1 1 2022 (6) communication skills; and (7) clinical skills. Lic. & Cert. Section (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based

Division of Health Service Regulation

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

Thomas Maxwell

Exec. Director

February 1, 2022

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) P

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED	
		MHL026-689	B. WING	B. WING		
NAME OF P	ROVIDER OR SUPPLIER	6777 CA	ADDRESS, CITY, S ANDLEWOOD D FEVILLE, NC 28	RIVE	12/10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	BE COMPLETE	
V 109	develop and implement for the initiation of an plan upon hiring each (g) The associate pro	dy for each facility shall not policies and procedures individualized supervision associate professional. fessional shall be ed professional with the the period of time as	V 109			
	one Licensee/Qualified failed to demonstrate the abilities required by the findings are: Cross Reference: G.S. CARE PERSONNEL Research and the control of t	ws and interviews, one of a Professionals (L/QP) he knowledge, skills and a population served. The \$131E-256 HEALTH EGISTRY (Tag V132). We and interviews, the that the Health Care CPR) is notified of all lith care personnel, failed be to protect the clients and failed to investigate NCAC 27G .0603 EREQUIREMENTS FOR PROVIDERS (Tag V366).		The QP will conduct an internal review, the necessary adjustments to ensure the and welfare of all parties when notified event. The QP will submit the required documents to the appropriate agencies the incident or alleged incident has beer reported. Such actions will be taken evereports come through their Therapist, LF other party's or officials that are involved development and welfare surrounding the consumers served. Where during this all incident it did not occur based on the conot reporting no such act until interviewe the surveyor on 12/08/21.	e safety of such after on if the or l in the e leged osumer	

Division of Health Service Regulation

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		MHL026-689	B. WING	B. WING		
NAME OF P	ROVIDER OR SUPPLIER	6777 CA	ADDRESS, CITY, STATE ANDLEWOOD DRIV FEVILLE, NC 28314	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD		D BE COMPLETE	
	Cross Reference: 10. INCIDENT REPORTI CATEGORY A AND E Based on record reviet failed to report Level the LME (Local Mana hours. Review on 12/08/21 or record revealed: - Date of hire: 02/02/0 - Abuse and neglect to Review on 12/08/21 or signed by the L/QP ar - "What immediate ac ensure the safety of the After the internal inverteporting allegations or - "Describe your plans happens. Create & su documents IRIS (Incid Improvement System) Registry) in a timely m Clients at the facility ra years old. The clients Attention Deficit Hyper Oppositional Defiant D and Conduct Disorder #8 had choked him an sink. Client #2 and clie witnessed this incident #8 was involved in and Staff #8 had gotten fru wall in client #2's bedre had been made aware between client #2 and	A NCAC 27G .0604 NG REQUIREMENTS FOR PROVIDERS (Tag V367). Eva and interview, the facility III incidents as required to gement Entity) within 72 If the L/QP's personnel 1. Taining completed 03/04/19. If a Plan of Protection and dated 12/08/21 revealed: tion will the facility take to ge consumers in your care? Estigation the protocol for will be followed." If to make sure the above bmit (the necessary lent Response report, HCR (Health Care granner." In the protocol for will be followed. The stage in age from 13 to 15 thave diagnoses to include fractivity Disorder, Anxiety Disorder. Client #1 had alleged staff dispersion of the protocol of th	V 109			

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		3:	COMPLETED		
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		MHL026-689	B. WING	B. WING		R 12/10/2021	
NAME OF D	DOMBED OF CURRY IS				12/	10/2021	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, ST				
LUV-N-AF	RMS		NDLEWOOD D				
			EVILLE, NC 28	314			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 121	Worker stated she ha 11/23/21 of the above documentation had be above incidents. No s been identified for the agencies had been no internal investigations the ensuring for the cl review of allegations a L/QP failed to demons decision-making abilitinecessary steps to proprocedures, notify reledocument these incider rule violation for serior corrected within 23 da penalty of \$2,000 is im corrected within 23 da administrative penalty imposed for each day compliance beyond the 27G .0209 (F) Medication review: (1) If the client receives	d notified the L/QP on a allegations. No been completed about the pecific dates or times had a incidents. No collateral offied of the allegations. No had been completed nor itents' safety during the as required. The fact the strate the required ites and failed to take the operly follow policies and evant agencies and must be as neglect and must be a neglect and	V 109	The interview conducted 11/23/21 by the OSS worker was an oversight by the Obecause it focused on the consumers' behaviors which included several epis thief in and attempt to throw off the dishe alleged the incident that was to have occurred in residential settings without when it was to have occurred.	peer odes of scussion		
	for obtaining a review of regimen at least every shall be to be performed physician. The on-site the client's physician is the review when medic	of each client's drug six months. The review ed by a pharmacist or manager shall assure that informed of the results of al intervention is indicated. drug regimen review shall nt record along with					

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/ELIPPLIED/CLIA	T (VO) LEU II TID	LE COMPTEMBLE.		
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	
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		MHL026-689	B. WING		1	R
					12/	10/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
LUV-N-A	RMS	6777 CAI	NDLEWOOD D	RIVE		
LOV-IV-A	T(WO	FAYETTI	EVILLE, NC 28	314		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES				
PREFIX		MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I		(X5)
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI		COMPLETE DATE
				DEFICIENCY)		
V 121	Continued From page	1	V 121			+
	Continued From page	• •	V 121			
				41.		
	This Rule is not met a	as evidenced by:		Th- 0D - 111		
	Based on record revie			The QP and Human Resource person	nel will	12/15/21
		n six-month reviews of the		ensure during consumer's record revie	ws that	
		its receiving psychotropic		their physicians list all prescribed and o	over the	
		one of three clients (#2).		counter medications to include psychol	горіс	
	The findings are:	one of three chefts (#2).		drugs in their progress notes.		
	rric infairigs are.					
	Review on 12/06/21 of	client #2's record				
	revealed:	Chefft #2 5 record				
	- 13 year old male.					
	- Admission date of 01	120,120				
		ct Disorder, Oppositional				
		ition Deficit Hyperactivity				
	Disorder (ADHD) Com					
	Disinhibited Social Eng					
	- No documented 6 mg	onth drug regimen review.		7		
	Review on 12/06/21 of	client #2's daily drug				
	regimen revealed:					
	- Divalproex (treats sei	zures) - 500 milligrams				
	(mg) twice daily.					ì
	- Guanfacine (treats hig					i
	ADHD) - 1mg one in ar					ļ
	- Melatonin (sleep aid)	- 5mg as needed at				ĺ
	bedtime.					-
	- Concerta (treats ADH)	D) - 18mg every morning.				
	- Zoloft (anti-depressan					I
	- Ziprasidone (anti-psyd	chotic) - 60mg twice daily.				
		nal allergies) - 1 spray in				
	nostril each day.	<i>5 ,</i> ,				
	- Proair HFA (treats asth	nma) - use as needed.				1
	(, 555 5550000.				- 1
	Interview on 12/08/21 th	ne Licensee/Qualified				- 1
	Professional stated:					- 1
		completed drug reviews				
	c registered radise	completed drug reviews			1	1

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) P

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	T/V	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN		(^	COMPLETED	
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						R	
	MHL026-689 B. WING				12/10/2021		
NAME OF E	PROVIDER OR SUPPLIER	OTDEET.	DDDDDD AITH				
TWINE OF T	NOVIDER OR SUFFLIER		DDRESS, CITY, S				
LUV-N-AI	RMS		NDLEWOOD				
		FAYETT	EVILLE, NC 28	3314			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTI	ION SHOULD BE	COMPLETE	
140	THE OBSTROKT ON E	SO BENTI THE IN CRIMATION)	TAG	CROSS-REFERENCED TO TO		DATE	
				DEFICIENC			
V 121	Continued From page	5	V 121				
	on the clients.						
	- He understood only	a physician or pharmacist					
		n drug regimen reviews per					
	rule.						
V 132	G.S. 131E-256(G) HC	PR-Notification,	V 132				
	Allegations, & Protecti						
	G.S. §131E-256 HEAL	TH CARE PERSONNEL					
	REGISTRY						
	(g) Health care facilitie	es shall ensure that the					
	Department is notified of all allegations against						
	health care personnel,	including injuries of					
		h appear to be related to					
		rision (a)(1) of this section.					
	(which includes:	(2)(1) 01 1110 0001011.					
		f a resident in a healthcare					
	facility or a person to w	whom home care services					
		IE-136 or hospice services				1	
	as defined by G.S. 131	E-201 are being provided.					
		f the property of a resident					
	in a health care facility	as defined in subsection					
	(b) of this section include	ding places where home					
	care services as define	ed by G.S. 131E-136 or					
	hospice services as de	fined by G.S. 131E-201					
	are being provided.						
	c. Misappropriation of	the property of a					
	healthcare facility.	proporty or a					
		pelonging to a health care					
	facility or to a patient or						
		alth care facility or against					
	a patient or client for wi	nom the employee is				1	
	providing services).						
	Facilities must have ev	idence that all alleged					
		nd must make every effort					
	to protect residents from	n harm while the					
	investigation is in progra						
	investigations must be i						
	pepartinent within live i	vorking days of the initial					

PRINTED: 01/04/2022 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R B. WING MHL026-689 12/10/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6777 CANDLEWOOD DRIVE LUV-N-ARMS FAYETTEVILLE, NC 28314** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 132 Continued From page 6 V 132 notification to the Department. This Rule is not met as evidenced by: The QP suspended the accused staff member. 12/08/21 Based on record reviews and interviews, the Conducted an internal review with staff and the facility failed to ensure that the Health Care consumers evident by, obtaining written statements, viewed surveillance footage and Personnel Registry (HCPR) is notified of all photos to determine when the alleged incident allegations against health care personnel, failed was to have occurred (11-11-21). The QP to put measures in place to protect the clients submitted the appropriate documents to the during the investigation and failed to investigate HCPR and IRIS. allegations of abuse. The findings are: Review on 12/06/21 and 12/08/21 of facility records from September 2021 thru present revealed no documentation of client #1 and client #2's allegations of abuse against staff #8. Review on 12/06/21 and 12/08/21 of client #1's

Division of Health Service Regulation

record revealed: - 13 year old male.

record revealed:

- Admission date of 07/30/21.

Unspecified Anxiety Disorder.

- Diagnoses of Attention Deficit Hyperactivity Disorder (ADHD) Combined Type, Disruptive Mood Dysregulation Disorder (DMDD) and

Review on 12/06/21 and 12/08/21 of client #2's

STATE FORM

	IT OF DEFICIENCIES	(***)		(X2) MULTIPLE CONSTRUCTION			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	COMPLETED	
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		MHL026-689	B. WING		1	2/10/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
LUV-N-AF	RMS	6777 C	ANDLEWOOD DRIV	E			
			TEVILLE, NC 28314				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y 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 132	Continued From page	e 7	V 132				
	- 13 year old male.						
	- Admission date of 0	1/30/20.					
	- Diagnoses of Condu	uct Disorder, Oppositional					
		D), ADHD Combined Type					
	and Disinhibited Social Engagement Disorder.						
	Review on 12/06/21 and 12/08/21 of client #3's						
	record revealed:						
	- 15 year old male.						
	- Admission date of 08	8/04/21.					
	- Diagnoses of Bipola						
		Disorder with Psychotic					
	Features.						
	Interview on 12/06/21	and 12/08/21 client #1					
	stated:	and revolve tollers with					
	- He was 13 years old						
	- He had a guardian th						
	Department of Social 3 - He recalled an incide						
1	between himself and s						
	- "He (staff #8) did cho						
	- Staff #8 put his hand:		!				
	- Staff #8 bent him tow						
	- His back was against	t the sink.					
	- "He (staff #8) actually couldn't talk."	y squeezed my neck. I					
		und the neck about "45					
	seconds."	and the neck about 45					
	- Staff #7 was at the fa	cility when the incident					
	occurred.						
1	- Client #2 told the Lice						
	Professional (L/QP) bu about the incident.	it he never told anyone					
	about the moldent.						
	Interview on 12/06/21 a stated:						
	- He had resided at the						
	- He was currently in 8t						
	 He recalled an incider 	nt between himself and					

Division of Health Service Regulation

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MULTIE	PLE CONSTRUCTION	Taxa a	
	OF CORRECTION	IDENTIFICATION NUMBER:	- 10 A		10 100 1000	E SURVEY MPLETED
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		MHL026-689	B. WING		1	2/10/2021
NAME OF F	DOMBED OF CLIPPLIES					2/10/2021
NAIVIE OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
LUV-N-AF	RMS	6777 CAI	NDLEWOOD D	PRIVE		
		FAYETTI	EVILLE, NC 28	3314		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(V5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETE
TAG	REGULATURY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
				DEFICIENCY)		
V 132	Continued From page	8	V 132			
	staff #8.					
		b				
		ber the date but he was				
	laying on his bed.	1 - 1 - 1 - 1 - 11				
	- Staff #8 punched a h	lole in his wall.				
	- Starr #8 got mad after	er he told him he was going				
	to get cancer from sm					
		member that recently died				
	from cancer.					
		vas at the facility when staff				
	#8 punched his wall.	well install and the second stall and				
	and it was patched.	wall just above his head				
		almad with an in side of 10				
		olved with an incident with				
	client #1 in October.	1000 - 1141 - 11				
	- "He (staff #8) choked					
		ed water on clean dishes.				
	- Staff #8 grabbed clien					
		1 back towards the sink.				
	- He did not see any in					
		cility during the incident.				
	- ne told L/QP about tr	ne incidents at the facility.				
	Interview on 12/06/21	olioma #2 oana di				
	- He was 15 years old.	client #3 stated:				
	 He resided at the facilities 	lity approximately 4				
		illy approximately 4				
	months. - He was admitted from	a payabiatria bassital				
	- He was admitted from	nt between client #1 and				
	staff #8.	it between client #1 and				
		ctober or November 2021.				
	- Client #1 had splashe					
	dishes.	d water off the clear				
		t #1 and pushed his head				
	into the sink.	m # r and pushed his flead				
	- Staff #8 was frustrated	d with client #1				
	- He had not spoken wit					
	incident.	in anyone about the				
	- He did not recall who t	the second staff -t th-				24
	facility was during the in					ĺ
	He did not see any inju	unes.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
ANDPLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED		
		BALLI 00C 000	B. WING			R		
		MHL026-689	D. WING			12/10/2021		
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST					
LUV-N-A	RMS		NDLEWOOD D					
(VA) ID	SUMMARYST	ATEMENT OF DEFICIENCIES	EVILLE, NC 28					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
V 132	Continued From page	9	V 132					
	stated: - She notified the L/QI allegations against stated: - He went to the facility - He was told that staff in client #2's bedroom - Staff #8 did not punce - The issue with staff # happened a couple of - He had not complete with staff #8 He discussed this with months ago He was not aware of staff #8 He had spoken with the everyday and no one bear The DSS Social Work an allegation staff #8.	Services Social Worker P of client #1 and client #2's aff #8 on 11/23/21. the L/QP stated: y every day. f #8 had "indented" the wall h a hole in the wall. 8 damaging the wall months ago. d a write up or supervision h staff #8 a couple of client #1 getting choked by the clients about issues brought up getting choked. Ser did not tell him about choked client #1. d any incident reports or le agencies. ended pending any ctions. referenced into 10 A MPETENCIES OF SIONALS AND SIONALS (V109) for a						
V-200	within 23 days.							
V 366	27G .0603 Incident Res	sponse Requirments	V 366					
	10A NCAC 27G .0603	INCIDENT						

EMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION		(X3) DATE SURVEY	
	IDENTIFICATION NOMBER.	A. BUILDING:	A. BUILDING:		COMPLETED	
	MHL026-689	B. WING		,	R 12/10/2021	
OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE			
N-ARMS	6777 CA	NDLEWOOD DE	RIVE			
		EVILLE, NC 283	114			
FIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
implement written pol response to level I, II shall require the provi (1) attending to of individuals involved (2) determining (3) developing a measures according to timeframes not to except (4) developing a to prevent similar incides pecified timeframes in (5) assigning perfor implementation of preventive measures; (6) adhering to eset forth in G.S. 75, Ald 42 CFR Parts 2 and 3 164; and (7) maintaining Subparagraphs (a) (1) (b) In addition to their Paragraph (a) of this Fishall address incidents regulations in 42 CFR (c) In addition to their Paragraph (a) of this Fishall address incidents regulations in 42 CFR (b) In addition to the reparagraph (a) of this Fishall address incidents regulations in 42 CFR (b) In addition to the reparagraph (a) of this Fishall address incidents regulations in 42 CFR (b) In addition to the reparagraph (a) of this Fishall address incidents regulations in 42 CFR (b) In addition to the reparagraph (a) of this Fishall address incidents regulations in 42 CFR (c) In addition to the reparagraph (a) of this Fishall address incidents regulations in 42 CFR (b) In addition to the reparagraph (a) of this Fishall address incidents regulations in 42 CFR (c) In addition to the reparagraph (a) of this Fishall address incidents regulations in 42 CFR (c) In addition to the reparagraph (b) of this Fishall address incidents regulations in 42 CFR (c) In addition to the reparagraph (b) of this Fishall address incidents regulations in 42 CFR (c) In addition to the reparagraph (b) of this Fishall address incidents regulations in 42 CFR (c) In addition to the reparagraph (b) of this Fishall address incidents regulations in 42 CFR (c) In addition to the reparagraph (b) of this Fishall address incidents regulations in 42 CFR (c) In addition to the reparagraph (b) of this Fishall address incidents regulations in 42 CFR (c) In addition to the reparagraph (c) of this Fishall address incidents regulations in 42 CFR (c) In addition to the reparagraph (c) of this Fishall address incidents regulations in 42 CFR (c	REMENTS FOR B PROVIDERS providers shall develop and licies governing their or III incidents. The policies ider to respond by: the health and safety needs if in the incident; the cause of the incident; and implementing corrective to provider specified eed 45 days; and implementing measures dents according to provider mot to exceed 45 days; erson(s) to be responsible the corrections and confidentiality requirements rticle 2A, 10A NCAC 26B, and 45 CFR Parts 160 and documentation regarding through (a)(6) of this Rule. equirements set forth in Rule, ICF/MR providers is as required by the federal Part 483 Subpart I. equirements set forth in lule, Category A and B	V 366				

STATEMEN	T OF DEFICIENCIES	(VA) DECYMEENS UPPLIED OUT						
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY		
	J. 33/11/2/1	IDENTIFICATION NOIMBER.	A. BUILDING	3:	COM	MPLETED		
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1		MHL026-689	B. WING			R		
		WITE020-005			1	2/10/2021		
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE				
1			NDLEWOOD D					
LUV-N-AF	RMS		EVILLE, NC 28					
	OUR MADE OF		EVILLE, NC 20					
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECT		(X5)		
TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU		COMPLETE		
			TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE		
V 366	Continued From page	11	V 366					
	(A) obtaining the	olient recent.						
		e client record;						
	(B) making a ph							
		e copy's completeness; and						
	(D) transferring	the copy to an internal						
	review team;							
	(2) convening a	meeting of an internal						
		hours of the incident. The						
		hall consist of individuals						
		in the incident and who						
		or the client's direct care or						
	with direct professiona	al oversight of the client's						
	services at the time of	the incident. The internal						
	review team shall com	plete all of the activities as						
	follows:							
	(A) review the co	ppy of the client record to						
		nd causes of the incident						
		lations for minimizing the						
	occurrence of future in							
		information needed;						
		preliminary findings of fact						
	within five working day							
		fact shall be sent to the						
		ent area the provider is						
		where the client resides,						
	if different; and							
		vritten report signed by the						
1		nths of the incident. The						
	final report shall be ser							
	catchment area the pro	vider is located and to the						
	LME where the client re	esides, if different. The				1		
	final written report shal	l address the issues						
	identified by the interna							
	include all public docur							
		e recommendations for						
		nce of future incidents. If						
	all documents needed							
	available within three m	nonths of the incident, the						
		ider an extension of up to						
	three months to submit							
	unce monus to submit	the infaireport, and						
		8						

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) P

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R 12/10/2021	
	MHL026-689		B. WING			
NAME OF P	ROVIDER OR SUPPLIER	6777 CA	DDRESS, CITY, ST	RIVE		10,2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	BE	(X5) COMPLETE DATE
	(3) immediately (A) the LME res, area where the service Rule .0604; (B) the LME who different; (C) the provider for maintaining and up treatment plan, if differ provider; (D) the Departme (E) the client's le applicable; and (F) any other au This Rule is not met as Based on record review	ponsible for the catchment es are provided pursuant to ere the client resides, if agency with responsibility odating the client's rent from the reporting ent; egal guardian, as thorities required by law.	V 366	The QP submitted the appropriate doct to the HCPR and IRIS.	uments	12/08/21
	- Client #1 and client #2 abuse against staff #8 The Licensee/Qualifie aware of staff #8 punch client #2 was in his bed client's behavior A local Department of Social Worker had notifiallegation of abuse client #8 on 11/23/21.	ed professional (L/QP) was ning client #2's wall while due to frustration from the Social Services (DSS) fied the L/QP of the nt #1 made against staff				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
ANDFLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	A. BUILDING:			LETED	
		MHL026-689	B. WING	B. WING		R 12/10/2021		
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE				
LUV-N-AF	RMS	6777 CA	ANDLEWOOD D	RIVE				
	1		TEVILLE, NC 28	314				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIAT		(X5) COMPLETE DATE	
	in client #2's bedroom - Staff #8 did not punc - The issue with staff # happened a couple of - He had not complete with staff #8 Staff #8 had a sister from cancer Client #2 had told sta as well He spoke with staff # away if he is upset He discussed this wit months ago He was not aware of staff #8 He had spoken with t everyday and no one b - The DSS Social Work an allegation staff #8 c	the L/QP stated: y every day. f #8 had "indented the wall" h a hole in the wall. #8 damaging the wall months ago. d a write up or supervision that recently passed away off #8 he could get cancer about grief and walking h staff #8 a couple of client #1 getting choked by he clients about issues rought up getting choked. Ger did not tell him about hoked client #1. d any incident reports for referenced into 10 A APETENCIES OF SIONALS AND SIONALS (V109) for a	V 366					
	27G .0604 Incident Rep	250 40 000000	V 367					
vision of Hooli	10A NCAC 27G .0604	INCIDENT						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL026-689		B. WING		R 12/10/2021		
NAME OF						
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	BE COMPLETE	
V 367	REPORTING REQUIF CATEGORY A AND B (a) Category A and B level II incidents, excethe provision of billable consumer is on the provincidents and level II of the town the provider in 90 days prior to the incresponsible for the cates services are provided becoming aware of the besubmitted on a form Secretary. The report in person, facsimile or means. The report shall information: (1) reporting providentification information: (2) client identification information: (3) type of incidentification of the cause of the incident; and the cause of the incident incid	REMENTS FOR PROVIDERS providers shall report all pt deaths, that occur during e services or while the oviders premises or level III deaths involving the clients rendered any service within cident to the LME chement area where within 72 hours of e incident. The report shall in provided by the may be submitted via mail, encrypted electronic all include the following vider contact and on; cation information; ent; fincident; effort to determine the and als or authorities notified roviders shall explain any information. The provider d report to all required end of the next business has reason to believe that the report may be or otherwise unreliable; or obtains information of form that was previously	V 367			

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTIPLE C	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		MHL026-689	B. WING		R 12/10/2021	
NAME OF F	PROVIDER OR SUPPLIER	6777 CA	ADDRESS, CITY, STATE ANDLEWOOD DRIV FEVILLE, NC 28314	E		
(X4) ID PREFIX TAG	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETE	
	obtained regarding the (1) hospital receinformation; (2) reports by o (3) the provider (d) Category A and B of all level III incident Mental Health, Develor Substance Abuse Serbecoming aware of the providers shall send a incidents involving a compression of the client death within sevor restraint, the providing mediately, as required 1.0300 and 10A NCAC (e) Category A and B preport quarterly to the catchment area where the report shall be substance Abuse Serbecoming aware of the client death within sevor restraint, the providing immediately, as required 1.0300 and 10A NCAC (e) Category A and B preport quarterly to the catchment area where the report shall be substanced to the post of a level II of (2) restrictive into the definition of a level II of (3) searches of a seizures of client (5) the total numincidents that occurred (6) a statement in been no reportable incidents have occurred meet any of the criteria	ther authorities; and se response to the incident. providers shall send a copy reports to the Division of opmental Disabilities and vices within 72 hours of incident. Category A copy of all level III lient death to the Division of et incident. In cases of en days of use of seclusion er shall report the death ed by 10A NCAC 26C 27E .0104(e)(18). Providers shall send a LME responsible for the services are provided. Promitted on a form provided ectronic means and shall mation as follows: provided that do not meet the revel III incident; erventions that do not meet III or level III incident; a client or his living area; ient property or property in ent; ber of level II and level III; and indicating that there have dents whenever no diduring the quarter that as set forth in Paragraphs and Subparagraphs (1)	V 367			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (IDENTIFICATION NI IMPERI		(X3) DATE SURVEY			
ANDPLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3:	COMPLETED	
		MHL026-689	B. WING		1	R / 10/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	FATE, ZIP CODE		73 200
LUV-N-AF	RMS	6777 CAN	IDLEWOOD D	RIVE		
			VILLE, NC 28	314		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		BE	(X5) COMPLETE DATE		
	failed to report Level II the LME (Local Managhours. The findings and Refer to V132 regarding - Client #1 and client #2 abuse against staff #8 - The Licensee/Qualificaware of staff #8 punched client #2 was in his beautient in the second worker had not allegation of abuse client #8 on 11/23/21. Review on 12/08/21 of Response Improvement from September 2021 Level III incident report Interview on 12/08/21 the was told that staff in client #2's bedroom. Staff #8 did not punched. The issue with staff #8 happened a couple of response of the couple of the	as evidenced by: w and interview, the facility II incidents as required to gement Entity) within 72 e: ag specific incident reports. 2 made allegations of . ed professional (L/QP) was hing client #2's wall while d due to frustration from the f Social Services (DSS) ified the L/QP of the ent #1 made against staff the North Carolina Incident at System (IRIS) website thru present revealed no is. the L/QP stated: every day. #8 had "indented the wall" a hole in the wall. B damaging the wall months ago.	V 367	The QP submitted the appropriate docto the HCPR and IRIS.	uments	12/08/21
		I a write up or supervision				

1	STATEMEN	NT OF DEFICIENCIES	Total provinces of the second					_
I		NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
ı	7 II D I D II V	O CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING	A. BUILDING:		COMPLETED	
ı								
I			BALLI 000 000	B WING	B. WING		R	
ŀ			MHL026-689	B. WING _		12	/10/2021	
I	NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE ZIP CODE			
١				NDLEWOOD D				
l	LUV-N-A	RMS						
ŀ		T		EVILLE, NC 28	3314			
	(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
l	TAG		SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRIA	E	COMPLETE	
l				IAG	DEFICIENCY)	(IE	DATE	
ŀ			7992					_
	V 367	Continued From page	e 17	V 367				
		- Staff #8 had a sister	that recently passed away					
		from cancer.	and recording paceed away					
		- Client #2 had told sta	aff #8 he could get cancer					
		as well.	get ad., 100.					
		- He spoke with staff #	#8 about grief and walking					
		away if he is upset.						
		- He discussed this wi	th staff #8 a couple of					
		months ago.						
		- He was not aware of client #1 getting choked by						
	į,	staff #8.						
		- He had spoken with the clients about issues						
			prought up getting choked.					
			ker did not tell him about					
		an allegation staff #8 of						
		 He had not complete 	d any incident reports nor					
		notification of applicab	le agencies as required.					
		This deficiency is cross	referenced into 10A					
		NCAC 27G .0203 COM						-
		QUALIFIED PROFESS						-
		ASSOCIATE PROFES	SSIONALS (V109) for a					1
		Type A1 rule violation a	and must be corrected					-
		within 23 days.						
	V 512	27D .0304 Client Right	s - Harm, Abuse, Neglect	V 512	Unan bis set and an			
			,,		Upon his return the QP verbally counse	led the	12/17/21	-
		10A NCAC 27D .0304	PROTECTION FROM		staff member about maintaining his			ı
		HARM, ABUSE, NEGL	ECT OR EXPLOITATION		composure when being confronted by a			No. of Concession,
			rotect clients from harm,		verbally aggressive clients or during a s situation when dealing with the consum-	tressful		١
			ploitation in accordance		Evident by stating, even though you did	ers.		
		with G.S. 122C-66.			touch or threaten the consumer, you she	ould		
			ot subject a client to any		not allow your temper to override your	Julu		ı
		sort of abuse or neglect	t, as defined in 10A NCAC		professionalism by responding hastily to	а		
		27C .0102 of this Chap			consumers provoking remarks or behav	iors.		The same of
		(c) Goods or services						
		purchased from a client						
		established governing b						1
								-
		necessary to repel or se	se only that degree of force					
		necessary to reper or se	ecure a violent and					
				1				4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3:	R 12/10/2021		
	MHL026-689	B. WING				
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
LUV-N-ARMS	6777 CAN	DLEWOOD D	RIVE			
	FAYETTE	VILLE, NC 28	314			
PREFIX (EACH DEFICIENCY	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	ON SHOULD BE COMPL HE APPROPRIATE DATE		
is necessary depends of characteristics of the cland physical and ments of aggressiveness dispintervention procedures Subchapter 10A NCAC (e) Any violation by an (a) through (d) of this R dismissal of the employ This Rule is not met as Based on record review four audited paraprofes	which is permitted by The degree of force that upon the individual lient (such as age, size al health) and the degree played by the client. Use of as shall be compliance with a 27E of this Chapter. The employee of Paragraphs and shall be grounds for are. The evidenced by: as and interviews, one of asional staff (#8) abused and #2). The findings are: and 12/08/21 of client #1's BO/21. Deficit Hyperactivity and Type, Disruptive arder (DMDD) and arder. and 12/08/21 of client #2's BO/20. Disorder, Oppositional ADHD Combined Type Engagement Disorder. 12/08/21 of client #3's	V 512				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-689		IDENTIFICATION NUMBER:	A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		B. WING	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	12/10/2021	
LUV-N-AI	RMS	6777 CA	NDLEWOOD DRIV	/E		
		FAYETT	EVILLE, NC 28314	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETE	
V 512	Continued From page	19	V 512			
V 512	- Diagnoses of Bipola Moderate Depressive Features. Review on 12/06/21 a Carolina Incident Resi (IRIS) from September revealed no Level III r #2's allegation of abus Review on 12/08/21 o log from September 2 no incident report doci	r Disorder, ODD and Disorder with Psychotic and 12/08/21 of the North ponse Improvement System or 2021 thru present eport about client #1 and se against staff #8. If the facility incident report 021 thru present revealed uments regarding client #1 abuse against staff #8. and 12/08/21 client #1 rough a local county Services (DSS). Int in October 2021 taff #8. Is around his neck. ards the kitchen sink. It squeezed my neck. I und the neck about "45	V 512			
	- Client #2 told the Lice Professional (L/QP) bu about the incident.					
	Interview won 12/06/21 stated: - He had resided at the - He was currently in 8t	facility for one year.				

		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL026-689		B. WING	B. WING			
NAME OF P	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE	12/10/2021	
LUV-N-AF	RMS		NDLEWOOD DRIVI EVILLE, NC 28314	E		
(X4) ID	SUMMARY ST		ID ID	PROVIDENCE PLANTOS CONTRACTOR		
PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETE	
V 512	Continued From page	20	V 512			
	and staff #8. - He could not rememilaying on his bed. - Staff #8 punched a his beget cancer from smin and staff #8 had a family cancer. - He thought staff #2 will #8 punched his wall. - Staff #2 punched the and it was patched. - Staff #8 was also invocitient #1 in October. - "He (staff #8) choked on the client #1 had splashed. - Staff #8 grabbed client #8 grabbed client #1 had splashed. - Staff #8 bent client #8 hed in the client #1 had splashed. - Staff #8 bent client #8 hed in the client #1 had splashed. - Staff #8 was also invocitient #8 grabbed client #1 had splashed. - Staff #8 was also invocitient #8 grabbed client #1 had splashed.	r he told him he was going oking. that recently died from vas at the facility when staff wall just above his head olved with an incident with [Client #1] out." ed water on clean dishes. Int #1's "neck."				
	staff #8 The incident was in O - Client #1 had splashe dishes.	lity approximately 4 a psychiatric Hospital. In the between client #1 and ctober or November 2021. It water on the clean It #1 and pushed his head It with client #1. It anyone about the				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY		
		IDENTIFICATION NUMBER:	A. BUILDING	3:		COMPLETED		
		MHL026-689	B. WING	B. WING		R		
		111112020-003				2/10/2021		
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE				
LUV-N-AF	RMS	6777 CA	NDLEWOOD D	RIVE				
	operators.	FAYETTI	EVILLE, NC 28	314				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE COMPL CAPPROPRIATE DEFICIENCY) CX5 COMPL CAPPROPRIATE DAT			
V 512	Continued From page	21	V 512					
	- He did not see any ir	njuries.						
	- He had not placed an intervention in the pass - He had not seen any clients He nor other staff ha - He had not choked a hole in the wall He had heard clients him fired 2 staff always worked - Client #2 had made a his previous facility. Interview on 12/06/21 - She had worked at the - She had not seen any abuse clients She had not seen any inappropriately.	ther agency. professional at this facility. professional at th						
	- She had worked for the							
	approximately 9 years.							
 2 staff worked at the facility per shift. She recalled an incident between client #1 and staff #8, but was not sure of a specific date. Client #1 had required multiple redirections due 								
	to behaviors and failed	to complete chores.						
	- Client #1 was beating	items with a clothes						
	hanger.	ant #41a ala a a a a a a						
	 Staff #8 completed cli attempted to take the c 							
		n staff #8's personal space						
	- I I I I I I I I I I I I I I I I I I I	. J.z no o porobilal opace				1		

Division of Health Service Regulation

STATE FORM

1 1	COMPLETED
MHL026-689 B. WING	R 12/10/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6777 CANDLEWOOD DRIVE FAYETTEVILLE, NC 28314	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE COMPLETE DEFICIENCY) (X5) COMPLETE DATE
And he moved him out of the way. - Client #2 began to get involved and be disruptive and she began to work with him. - She never saw staff #8 hit or choke any of the clients. - The clients have said in the past they were going to get staff fired. - She had not seen staff #8 threaten or harm any of the clients. 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. - 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 as well. - He spoke with staff #8 about grief and walking away if he is upset. - He discussed this with staff #8 a couple of months ago. - No incident report was generated nor any other required reporting procedures. - He was not aware of client #1 getting choked by staff #8. - He had spoken with the clients about issues everyday and no one brought up getting choked. - The clients had stated they were trying to get staff #6 fired. - 2 staff work per shift at the facility. - The Department of Social Services (DSS) Social Worker did not tell him about an allegation staff #8 choked client #1. - Client #2 frequently lies.	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	(X3) DATE SURVEY COMPLETED				
			MHL026-689	B. WING		R 12/10/2021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6777 CANDLEWOOD DRIVE FAYETTEVILLE, NC 28314							
	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE
		- He had not complete notification of applicate - Staff #8 was not suspinto his actions. Review on 12/08/21 or signed by the L/QP and - "What immediate act ensure the safety of the Based on the informate staff member will be in actions. A internal invector onducted." - "Describe your plans happens. Statements or consumers & staff." Clients at the facility rayears old. The clients I ADHD, ODD, Anxiety I Disorder. Staff #8 chole back over the sink. Clie witnessed the incident. #8 got frustrated with chole in client #2's bedrebeen made aware of the #2 and staff #8 and haredirection. No docume completed about the all dates or times had bee incidents. This deficience rule violation for seriou corrected within 23 day penalty of \$2,000 is improrrected within 23 day penalty of \$2,000 is improrrected within 23 day penalty of \$2,000 is improrrected within 23 day	d any incident reports or ole agencies. Deended for an investigation of a Plan of Protection d dated 12/08/21 revealed: ion will the facility take to e consumers in your care? ion recently relayed the atterviewed and for alleged estigation will be to make sure the above will be collected from the olisorder and Conduct and Conduct and Cient #1 and bent his ent #2 and client #3. On another occasion staff client #2 and punched a coom wall. The L/QP had his incident between client do provided only verbal entation had been cove incidents. No specific an identified for the cove incidents a Type A1 as abuse and must be a san additional of \$500.00 per day will be the facility is out of	V 512			



February 4, 2022

Mental Health Licensure & Certification Section 1800 Umstead Dr. Raleigh, NC 27603

Re: Follow up Survey MHL 026-689 Intake# NC00183677

To whom it may concern,

Please excuse the tardiness of this Plan of Correction for Luv n Arms. The agency is just recovering from dealing with an episode of the COVID-19 virus in the residential setting. Enclosed is the Plan of correction regarding the intake NC00183677. An informal review and appeal has been requested at this time.

Please do not hesitate to contact me if I am able to assist you with further information regarding this matter. As we continue to provide the quality service expected to our valuable customers.

Respectfully,

Thomas Maxwell Exec. Director S & T WeCare Inc.



