STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(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 February 2, 2022. The complaint was substantiated (intake #NC00184834). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1800 Intensive Residential Treatment for Children and Adolescents. The survey sample consisted of 4 current clients.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(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 112	Continued From page 1	V 112		

This Rule is not met as evidenced by:
Based on record review and interviews the facility failed to develop and implement goals and strategies to address client needs for 1 of 4 audited clients (#4). The findings are:

Review on 02/01/22 of client #4's record revealed:
-15 year old male.
-Admission date of 10/06/21.
-Diagnoses of Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder and Depressive Disorder.
-Person-Centered Plan (PCP) dated 09/17/21 did not include any goals or strategies to address suicidal ideations and eating harmful objects.

Review on 02/01/22 of the facility's incident/accident reports dated 12/29/21 and 01/30/22 revealed:
-"(12/29/21)Written Statement: While walking down the hallway staff 1 overheard consumer [Client #4] arguing with another staff member and walked in to intervene. Consumer [Client #4] got extremely upset and began to curse and threaten staff. Consumer [Client #4] continued to be verbally aggressive and had to be restrained by staff. After the incident calmed down a little consumer [Client #4] then broke his glasses and swallowed a piece of his lenses. Staff took the glasses and notified other staff and GHM (Group Home Manager) was called and made aware of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(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 112	Continued From page 2	V 112		

the incident.
-The consumer was discharged to the facility (from the hospital) on 12-30-2021 and has had no further incident. The medical provider at the emergency room cleared the consumer medically and psychologically with no lasting effects. The medical doctor was unable to confirm through images and scans the presence of any lens in the consumers body. The advice was to monitor the consumer, and seek follow-up care if needed. No additional care was required.
-(1/30/22)Assessment/Treatment: 9:30pm Client (Client #4) swallowed screw. No change. 10:30pm Client swallowed screw, stated tasted blood. 11:30pm Client swallowed screw, still tasted blood.
-Narrative: After taking medications around 9:30pm [Client #4] started walking in restricted areas, he then found a screw. Staff (Staff #3) prompted client to hand over the screw and calm down. Client refused, then swallowed the screw. Client was offered a stool softner to help get it out.
-Written Statement: After giving out medications [Client #4] started having behavior. As I was doing notes and looking over my MAR (medication administration record) book, I heard staff telling him to 'stop. [Client #4] sit down, Go to bed.' Client refused. Due to all consumers being in their rooms we allowed [Client #4] to sit up front to try and calm down. Client then walked down the hall. When client came up the hallway staff noticed client had a screw. Client was asked to hand over the screw multiple times. Client kept playing like he would swallow it, but as staff tried to take the screw he swallowed it. Client then stated that he tasted blood and his throat hurt. Client was offered a stool softner to try to help but he refused. Client sat with 2nd shift staff until 3rd shift come in. Client then went to talk with a 3rd

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(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 112	Continued From page 3	V 112		

shift staff.
-Written Statement: Seen the peer playing with the screw put in and out of his mouth. But when the house manager call he swallow the screw in front of us. Now complaint of wanting to go to the hospital he taste blood. Ask him to go to bed at 8:30pm but he refuse to go to bed at 8:30pm kept saying she told him to stay up.
-Written Statement: After peer gave meds (medication) out [Client #4] started acting up with the screw threatening to keep swallow a screw. So peers try to stop the incident from happen. [Client #4] started walking away and swallow and taking it but until we call supervisor and right then and there he swallow it.
-Written Statement: Around the time staff was giving out medicine [Client #4] was having behaviors. 8:30pm we told everyone to go to bed but [Client #4] refused to go. Myself and every other staff have told him to go to bed but again he refused to listen. He took a screw out his pocket. I asked him where he got it from and for him to give it to me but he refused to do that as well. I then proceeded to tell the male staff's they have to get the screw from him but nothing was done. [Client #4] came back to me said he was calm and that he apologize. I acknowledge everything he was saying and ask for him to hand over the screw again...
-Written Statement: Consumer [Client #4] had been walking up and down the hallway as well as refusing to go to bed. He kept grabbing random things in the living room and being told by staff repeatedly to put them down and go to bed which he refused to do. [Client #4] kept mentioning wanting to hurt himself so he could leave. Eventually GHM (Group Home Manager) was notified once [Client #4] began to talk to her he then pulled a screw out of his pocket and swallowed it. GHM was notified and consumer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(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 112	Continued From page 4 was closely monitored until GHM arrived." During interview on 02/01/22 client #4 revealed: -He was 15 years old. -He had lived at the facility for 4 months. -He had "problems." -He was suicidal. -He ate a piece of his glasses after he broke them (12/29/21). -He swallowed a screw from his room. During interview on 02/01/22 the Qualified Professional (QP) revealed: -Client #4 has threatened to swallow items 4 times since 12/29/21. -Two of those occasions he swallowed objects. -On 12/29/21 client #4 went to the hospital for ingesting a piece of glass from his eyeglasses and stayed overnight for observation. -Client #4 had done this multiple times before in the past. -Client #4's mother informed her client #4 did the same behaviors when he was living with her. -Client #4 would sometimes swallow things and sometimes he would not. -Client #4 would make threats he was going to do something to himself if something happens that he does not like. -Client #4's mother had informed the QP that client #4 had done that behavior of eating items in the past. -She thought she had added the information of client #4 eating objects in the PCP because it was discussed during the last Child and Family Treatment meeting. -She had not added a goal or strategies but she had included the information in the notes of progress on the PCP. This deficiency is cross referenced into 10A	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(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 112	Continued From page 5 NCAC 27G .1801 SCOPE (V301) for a Type A1 rule violation and must be corrected within 23 days.	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure disaster drills were held quarterly and repeated on each shift. The findings are: Review on 02/01/22 of facility records from January 2021 thru December 2021 revealed: - No disaster drills documented for 2nd and 3rd shift for the 1st quarter of 2021. - No disaster drills documented for 1st and 3rd shift for the 2nd quarter of 2021. - No disaster drills documented for 1st and 2nd shift for the 3rd quarter of 2021.	V 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(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 114	Continued From page 6 - No disaster drills documented for 2nd or 3rd shift for the 4th quarter of 2021. Interview on 02/1/22 the House Manager stated: - The facility had three shifts daily. - 1st shift 7am to 3pm. - 2nd shift 3pm to 11pm. - 3rd shift 11pm to 7am. Interview on 02/01/22 the Qualified Professional stated: - She understood disaster drills should be conducted quarterly and repeated on each shift. - She would follow up to ensure the disaster drills were completed as required by rule.	V 114		
V 301	27G .1801 Intensive Res. Tx. Child/Adol - Scope 10A NCAC 27G .1801 SCOPE (a) An intensive residential treatment facility is one that is a 24-hour residential facility that provides a structured living environment within a system of care approach for children or adolescents whose needs require more intensive treatment and supervision than would be available in a residential treatment staff secure facility. (b) It shall not be the primary residence of an individual who is not a client of the facility. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, severe emotional and behavioral disorders or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for acute inpatient psychiatric services. (d) The children or adolescents served shall require the following:	V 301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(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 301	Continued From page 7 (1) removal from home to an intensive integrated treatment setting; and (2) treatment in a locked setting. (e) Services shall be designed to: (1) assist in the development of symptom and behavior management skills; (2) include intensive, frequent and pre-planned crisis management; (3) provide containment and safety from potentially harmful or destructive behaviors; (4) promote involvement in regular productive activity, such as school or work; and (5) support the child or adolescent in gaining the skills needed for reintegration into community living. (f) The intensive residential treatment facility shall coordinate with other individuals and agencies within the child or adolescent's system of care. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to coordinate with other individuals and agencies within the child or adolescent's system of care affecting 1 of 4 audited clients (#4). The findings are: Cross Reference: 10A NCAC 27G .0205 (c) Assessment and Treatment/Habilitation or Service Plan (V112). Based on record review and interviews the facility failed to develop and implement goals and strategies to address client needs for 1 of 4 audited clients (#4).	V 301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(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 301	Continued From page 8 Review on 02/01/22 of client #4's record revealed: -15 year old male. -Admission date of 10/06/21. -Diagnoses of Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder and Depressive Disorder. Review on 02/01/22 of the Registered Nurse (RN) note dated 01/31/22 revealed: - "...Ambulatory consumer (client #4) stated that he swallowed a screw. Was given a stool softener and is being monitored by staff on a 1:1 monitor then say he want to commit suicide..." During interview on 02/01/22 client #4 revealed: -He was 15 years old. -He had lived at the facility for 4 months. -Sunday night (01/30/22) he swallowed a screw. -He had asked to be taken to the hospital several times and no one would take him. -It was a long screw. -He got the screw out of the outlet in his room. -The nurse would not let him go to the hospital. -He had been "pooping" blood and his stomach was hurting. -Staff #3 was on the phone with 911 and the Qualified Professional (QP) told her to hang the phone up. -He felt sharp pains in this stomach and he was tasting blood. -He was suicidal. -The nurse went to the facility on 01/31/22 and she told him nothing was wrong with him. -He really felt like he needed to go the emergency room (ER). Interview on 02/01/22 staff #3 stated: -She recalled the incident on 01/30/22 with client	V 301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(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 301	Continued From page 9	V 301		

#4.
-She worked the 2nd shift, 3pm to 11pm.
-She was reviewing medications and client #4 was up and down the hallway.
-Client #4 had a screw and kept acting like he was putting it in his mouth.
-Client #4 wanted to speak with the QP or House Manager.
-She never saw the screw again and it was not recovered.
-She contacted Emergency Medical Services (EMS) to assist.
-The House Manager called and stated the RN requested a laxative to be given to client #4 and suicide watch for 24 hours.
-She canceled EMS and they said to call back if needed.

Interview on 02/01/22 staff #5 stated:
-She recalled the incident with client #4 on 01/30/22.
-It was approximately 8:30pm and client #4 would not go to his room.
-Staff attempted to engage him in a card game.
-Client #4 stated "he was bored and wanted to get into something."
-Client #4 walked up and down the hallway.
-He had a screw and get putting it in his mouth and taking it out.
-Staff encouraged client #4 to give up the screw.
-Client #4 stated he swallowed the screw.
-The House Manager was called and the decision was made by the RN to administer a laxative and monitor client for 24 hours.
-The staff never saw the screw again.

Interview on 02/01/22 the House Manager stated:
-She was notified client #4 had swallowed a screw on 01/30/22.
-She had spoke with client #4 via phone.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(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 301	Continued From page 10 -She contacted the QP about the incident. -The QP stated she had spoken with the RN and said to give client #4 a laxative. -Client #4 was monitored 24 hours for any physical issues. -She felt client #4 should have gone to the ER. -She would have sent client #4 to ER if it had been her decision. During interview on 02/01/22 the facility's RN revealed: -She visited the facility two to three times a month and more if things were going on. -She was aware client #4 said he swallowed a screw. -The QP called her and informed her of the incident. -She asked if the staff actually saw him swallow the screw and she was told no. -She told the staff since no one actually observed him swallowing the screw to give client #4 a stool softener and provide 1:1 supervision for 24 hours. -She saw client #4 the day after the incident and he stated he had a bowel movement and saw blood in his stool and his stomach was hurting. -She told client #4 to inform staff of his next bowel movement so staff could detect any blood in his stool. -Before he had swallowed a piece of glass from his glasses lens and he was taken to the emergency room. -With COVID and being crowded in the emergency room she informed the staff to just monitor him after the screw incident. -She was not told client #4 had placed a screw in and taken it out of his mouth several times. -She would follow up with facility staff. During interview on 02/01/22 the QP revealed: -She had just started working at the facility on	V 301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(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 301	Continued From page 11 December 29, 2021. -She was informed by staff on the evening of 01/30/22 that client #4 had swallowed a screw. -She called the RN and informed her that staff witnessed client #4 swallow the screw. -The RN informed her for staff to give client #4 a stool softener and monitor him 1:1 for any changes in client #4. -Client #4 had done this multiple times before in the past. -Client #4's mother informed her client #4 did the same behaviors when he was living with her. -Client #4 would sometimes swallow things and sometimes he would not. -Client #4 would make threats he was going to do something to himself if something happens that he does not like. -Client #4 went to the ER for swallowing glass from his glasses. -The ER sends the clients back to the facility. -The nurse did not want him going to the ER because of COVID. -Sending client #4 to the hospital also encouraged him to participate in the behavior of eating things. -The RN said if client #4 got sick throwing up or had blood in his stool then client #4 would need to go for further evaluation. Client #4 said he had blood in his stool but flushed the commode before anyone could see it. -She made the decision to not send him to the ER by going off of the nurses evaluation of him. -Client #4 told her he "couldn't breathe this morning" and she asked him several questions and determined he did not need to go to the hospital. -She offered him a stool softner and he refused. -Client #4 has had two behaviors of eating things since his last Child Family Team (CFT)meeting. -The next CFT meeting a different crisis plan is	V 301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(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 301	Continued From page 12	V 301		

going to be discussed and also discuss if client #4 needs a higher level of care.

During interview on 02/02/22 the Residential Director revealed:
-She was told on 02/01/22 client #4 had stated he swallowed a screw.
-Staff should have sent him to the emergency room.
-Client #4 had a doctor's appointment today.
-She would address the decision not to send client #4 to the emergency room with the RN.

Review on 02/02/22 of the Plan of Protection dated 02/02/22 and completed by the QP and the Residential Director revealed:
"-What immediate action will the facility take to ensure the safety of the consumers in your care? Qualified Professional will ensure that all consumers get medical concerns and emergency incidents evaluated by a medical provider within two hours of occurrence with transportation provided by Renewing Grace Home, if applicable. If the consumer cuts themselves, ingests objects or other non-food items, or otherwise is involved in an incident that places them in eminent harm, the Consumer will be transported to received medical care by emergency response vehicle (i.e., EMS, Ambulance, fire/paramedic). QP will ensure that PRN (as needed) medications procedures are followed to ensure maximum comfort for the consumer during the stressful incident. For instance, should the consumer have a hand nail/bite their nails causing bleeding, stub their finger, hand or toe and require, Tylenol, ice, etc. QP will ensure that ALL incidents be recorded and written as per their appropriate incident level and signed by the qualifying medical professional (Nurse).
-Describe your plans to make sure the above

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(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 301	Continued From page 13	V 301		

happens. Qualified Professional will address this new policy with the Home Manager, and Nurse, within 14 hours of the origination of this document; and instruct them to brief all staff about the protocol and procedure for handling such incidents. A step by step guide will be posted in the office for staff review and reference. The residential Director will follow-up to ensure that these briefings take place."

Client #4 is a 15 year old male with diagnoses to include Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder and Depressive Disorder. Client #4 had a history of self injurious behavior to include swallowing objects and goals and strategies were not included on the Person-Centered Plan. On 01/30/22 client #4 was observed by several staff to have a screw and placed it in and out of his mouth. Client #4 later stated he swallowed the screw. The screw had not been recovered. Staff reached out to the House Manager, QP and RN. The decision was made to attempt to administer a laxative and provide 1:1 observation for 24 hours while monitoring for any physical issues. The RN assessed client #4 on 01/31/22. Client #4 was complaining of an upset stomach, passing blood in his stool and tasting blood after the incident. The facility neglected to coordinate with agencies within the child or adolescent's system of care for a potential emergency and failed to develop and implement goals and strategies to address the self injurious behavior/eating harmful non-food objects. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $3,000.00 is imposed. if he violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for failure to correct within 23 days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(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 304	27G .1804 Intensive Res. Tx. Child/Adol - Min staffing 10A NCAC 27G .1804 MINIMUM STAFFING REQUIREMENTS (a) A Qualified Professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) If children or adolescents are cared for in separate units/buildings, the minimum staffing numbers shall apply to each unit/building. (c) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) three direct care staff shall be present for up to six children or adolescents; (2) four direct care staff shall be present for seven, eight or nine children or adolescents; and (3) five direct care staff shall be present for 10, 11 or 12 children or adolescents. (d) During child or adolescent sleep hours three direct care staff shall be present of which two shall be awake and the third may be asleep. (e) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(d) of this Rule, more direct care staff may be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to meet the minimum staffing requirements. The findings are:	V 304		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(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 304	Continued From page 15 Review on 02/01/22 of client #1's record revealed: - 17 year old male. - Admission date of 10/29/21. - Diagnoses of Oppositional Defiant Disorder, Conduct Disorder, Sleep Apnea, Mild Intellectual Developmental Disability and Obesity. Review on 02/01/22 of client #7's record revealed: - 17 year old male. - Admission date of 09/10/21. - Disruptive Mood Disorder, Major Depressive Disorder and Anxiety Disorder. Review on 02/01/22 of the facility's incident/accident report dated 01/31/22 revealed: "-On January 31, 2022 around 2:40pm consumer A (client #1) and consumer B (client #7) were both outside when consumer A went up for a lay up (basketball) and consumer B was in the way. Consumer A asked consumer B to get out the way while they were playing ball when consumer B then became physically aggressive and swung on consumer A. Staff grabbed both consumers. Consumer B was laying on the ground for a minute saying his head hurts, but then came in and layed in the bed until he was taken to the ER (emergency room) by the home manager." Review on 02/01/22 of client #7's hospital discharge report dated 01/31/22 revealed: "-Reason for Visit: Assault Victim Diagnoses: Assault, Closed fracture of left orbital eye." Observation on 02/01/22 at approximately 1:15pm revealed: -Client #7's left eye was red on the white internal	V 304		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(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 304	Continued From page 16 part of the eye. The left eye was swollen and black and blue around the entire eye. Interview on 02/01/22 client #7 stated: - He was 17 years old. - He had resided at the facility for approximately 6 months. - He recalled an incident on 01/31/22 with client #1. - He had walked out of the facility into the courtyard. - Client #1 did not like him. - He did not recall who the other clients in the courtyard were. - He got hit in the eye and his head several times by client #1. - Staff #2 and staff #4 were the only 2 staff in the court yard when he got hit by client #1. - The staff attempted to separate him and client #1. - Staff #2 was not able to move client #1 away from him. - He was taken to the emergency room and was diagnosed with an Orbital Fracture. - He is supposed to have an appointment with an eye doctor. - His eye was still hurting. Interview on 02/01/22 client #1 stated: - He was 17 years old. - He had resided at the facility for approximately 3 months. - He had been in an altercation with client #7 on 01/31/22. - He was playing basketball with other clients. - Client #7 was walking near the court and he asked client #7 to move. - Client #7 hit him and they began to fight. - Staff #1 tried to move client #7 but he kept	V 304		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(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 304	Continued From page 17 coming. - He hit client #7 because he kept coming after him. - Staff #2 and staff #4 were the only 2 staff outside and attempted to separate them. - He did not try to start any problems. - He was trying to move to independent living and did not display any aggression at the facility. Interview on 02/01/22 staff #1 stated: - He had worked at the facility for 9 months. - He recalled the incident on 01/31/22 between client #1 and client #7. - He and staff #4 were outside with 5 other clients and they were playing basketball. - Client #7 came outside and was walking by the court. - Client #1 asked client #7 to move away from the court. - Client #7 said "I am not on the f*****g court." - Client #7 swung on client #1 and they began to fight. - He got between the two clients and they kept coming back after being separated. - The two clients were difficult to separate. - Client #1 had hit client #7 in the eye. - Staff convinced client #7 to go to the emergency room for treatment. - Staff #4 was also outside at the time of the incident and a total of six clients. Interview on 02/02/22 staff #4 stated: - She had worked at the facility since June 2021. - She recalled the incident between client #1 and client #7 on 01/31/22. - She and staff #1 were outside with several clients. - She had just started her shift at 3pm. - She and staff #1 were watching the clients play basketball and client #7 walked outside.	V 304		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(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 304	Continued From page 18 - Client #7 usually comes outside for a few minutes and goes back in. - She did not see the initial cause of the altercation. - Staff #1 told her client #7 swung on client #1. - She only saw one good hit when client #1 hit client #7. - The staff attempted to separate client #1 and client #7. - "I couldn't hold the other boy (client #1)." - She thought all the 11 clients were outside except one. - The incident went on for a few minutes. During interview on 02/01/22 the Qualified Professional (QP) revealed: -She was investigating the incident between client #1 and client #7 and had only been able to interview client #1. -When the clients are outside a "staggering process" for the staff may need to occur. -She was told one of the eleven children was in the facility and the rest of the clients were outside. -She was told one staff was at the door and the rest of the staff went outside when the incident occurred. -Each shift has 5 staff and we currently have 11 clients. Interview on 02/02/22 the Residential Director stated: - She was investigating the incident between client #1 and client #7 on 01/31/22. - There should have been at least 3 staff outside with the 6 clients on 01/31/22. - She would address the lack of staff during the incident. - The facility wanted to protect all the clients in the facility.	V 304		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(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 304	Continued From page 19 Review on 02/02/22 of the Plan of Protection dated 02/02/22 completed by the QP and Residential Director revealed: "-What immediate action will the facility take to ensure the safety of the consumers in your care? Qualified Professional will meet with the Home Manager and TA (Teacher Assistant) staff to provide corrective In-Service Training concerning the policies governing ratio compliance while on campus/premises of Renewing Grace Residential Home. The training will specifically detail number of Staff per consumer at any given time during each shift. QP will immediately schedule said training with Home Manager and Staff. Qualified Professional will immediately perform an in-service training with the Home Manager in regard to scheduling to ensure that all shifts are appropriately covered per the number of consumers within the facility. QP will approve and sign all schedules created by the Home Manager to ensure that the shifts are fulfilled in compliance with ratio policies. -Describe your plans to make sure the above happens. Qualified Professional will schedule shift specific meetings, one to take place on first shift, second shift, and third shifts, to ensure that all staff member attend the meeting. The meeting will consist of an agenda, handouts, and signatures of all employees to document their participation in compliance with this corrective action. Qualified Professional and Home Manager will go to the facility as soon as possible when an incident occurs. QP will instruct other staff that were not involved in the incident to remove the injured consumer from the situation and stay with them until the appropriate authorities get to the facility. The consumer deemed the 'aggressor' will be removed to their room with one on one staff. During this time, QP will have a designated room	V 304		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(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 304	Continued From page 20	V 304		

to start internal investigation. The Residential Director will oversee to make sure all trainings are complete and implemented as needed. Each week QP will review the schedule with the Home Manager and revise as needed to ensure compliance. QP will provide in-service trainings on an ongoing basis to remind Home Manager and staff about ratio. Each staff member will receive a ration handout for their records. Also, a ratio memo will be posted in the Office for quick reference."

Clients at the facility are adolescents ranging in ages of 14 years old to 17 years old and their diagnoses included Disruptive Mood Disorder, Major Depressive Disorder,Oppositional Defiant Disorder, Conduct Disorder, Mild Intellectual Developmental Disability and Anxiety Disorder. On 01/31/22 a total of 6 clients were outside in the courtyard with 2 paraprofessional staff instead of the 3 required staff. An altercation occurred between client #1 and client #7, both 17 years old. Client #7 sustained an Orbital Fracture and required emergency medical treatment. Client #7 and client #1 exchanged multiple blows. Staff #4 reported she was not strong enough to hold client #1. The lack of minimum staffing while clients were outside presented an opportunity for the fight to escalate and client #7 received a closed fracture of the left orbital eye. The facility neglected to ensure that minimum staff were present. This deficiency constitutes a Type A1 rule violation for serious harm and neglect and must be corrected within 23 days. An administrative penalty of $3,000.00 is imposed. if he violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for failure to correct within 23 days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(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 752	Continued From page 21	V 752		
V 752	27G .0304(b)(4) Hot Water Temperatures 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit. This Rule is not met as evidenced by: Based on observation and interview, the facility water temperatures were not maintained between 100-116 degrees Fahrenheit in areas where clients were exposed to hot water. The findings are: Observation on 02/01/22 at approximately 10:36am of the 2 hallway client bathrooms revealed a hot water temperature of 88 degrees Fahrenheit. Interview on 02/01/22 the House Manager stated: - The hot water temperature was checked monthly. - She thought the last reading for the hot water was 101 degrees Fahrenheit. Interview on 02/02/22 the Residential Director stated: - She was aware the hot water temperature was required to be between 100 and 116 degrees Fahrenheit. - She would follow up on the water temperature at the facility.	V 752		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(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