Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED			
,		152.111.16/11.1611.11611.521.1	A. BUILDING: _			
			D MINO		R	
		MHL080-222	B. WING		02/04/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
DEVIVE H	OLIGINO LLO	523 NOR	TH LONG STRE	ET		
REVIVE H	OUSING, LLC	SALISBU	RY, NC 28144			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)		
V 000	INITIAL COMMENTS		V 000			
	Type A's was completed limited follow up surveduced. 0209 Medication Reconstruction NCAC 27G .1701 Section 1704 Minimum Staffit 10A NCAC 27E .0107 Restrictive Intervention 27E .0108 Training in Restraint, and Isolation reviewed for compliar brought back in compulation .0209 Medication Reconstruction NCAC 27G .1704 Min Requirements (V296) Training on Alternative Interventions (V536), Training in Seclusions Isolation Time-Out (V	, 10A NCAC 27E .0107				
	category: 10A NCAC Treatment Staff Secu Adolescents.	d for the following service 27G .1700 Residential re for Children and d of audits of four current				
V 293	27G .1701 Residentia	al Tx. Child/Adol - Scope	V 293			
	children or adolescen free-standing residen intensive, active thera interventions within a	ment staff secure facility for ts is one that is a tial facility that provides				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of	<u>of Health Service Regu</u>	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		MHL080-222	B. WING		02/04/2022
NAME OF D		STREET AS	DRESS, CITY, STA	TE 7ID CODE	
NAIVIE OF PI	ROVIDER OR SUPPLIER		, ,	,	
REVIVE H	OUSING, LLC		TH LONG STRE	ET	
	,	SALISBU	RY, NC 28144		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE
				DEFICIENCY)	
V 293	Continued From page	<u>.</u> 1	V 293		
. 200	Continued i form page	, 1	1 200		
	who is not a client of	the facility.			
	(b) Staff secure mean	ns staff are required to be			
		leep hours and supervision			
	•	s set forth in Rule .1704 of			
	this Section.				
		erved shall be children or			
		e a primary diagnosis of			
	mental illness, emotion				
		orders; and may also have			
		•			
	-	s including developmental			
		ildren or adolescents shall			
		patient psychiatric services.			
		dolescents served shall			
	require the following:				
	` '	m home to a			
	community-based res	idential setting in order to			
	facilitate treatment; a	nd			
	(2) treatment in	a staff secure setting.			
	(e) Services shall be	designed to:			
	(1) include indiv	vidualized supervision and			
	structure of daily living	g;			
		e occurrence of behaviors			
	related to functional d				
		ty and deescalate out of			
	control behaviors incl				
		without physical restraint;			
	•	nild or adolescent in the			
	· /	e functioning in self-control,			
		•			
		all and recreational skills; and			
		child or adolescent in			
		ded to step-down to a less			
	intensive treatment se				
	` '	atment staff secure facility			
	shall coordinate with				
	-	nild or adolescent's system			
	of care.				

STATE FORM 6899 If continuation sheet 2 of 10 BEF911

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
74401 2744	or dorate of the transfer of t	IDEITH IO/HIGH HOMBER.	A. BUILDING: _	A. BUILDING:		
		MHL080-222	B. WING		R 02/04/3	2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
REVIVE H	OUSING, LLC		H LONG STRE	ET		
			RY, NC 28144	PP0//PFP/2 P/ AV 25 22PP52T/2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 293	Continued From page	2	V 293			
	failed to ensure coord individuals and agend adolescent's system of clients (Client #1). The Review on 1-10-22 of revealed: -Hire date 5-24-221.	ew and interviews the facility dination of care with other sies within the child or of care effecting one of four e findings are: f Former Staff #1's record e1, termination date 12-10- d Based Protective				
	Review on 1-7-22 of 0 -Admitted 7-1-21 -Diagnoses of At Conduct Disorder and Dysregulation Disorde -16 years oldAssessment dat presenting problems; thinking, aggression, Review on 1-18-22 of for the incident on 11- signed by the Directo -"On 11/20/21 [Q Professional/Register a call from staff memory	Client #1's record revealed: .tention Deficit Disorder, d Disruptive Mood er. led 6-7-21 revealed posturing, delusional and gaslighting. If the facility's investigation -20-21 dated 12-10-21 and r revealed: led lifted led Nurse (QP/RN)] received loer (Former Staff #1) to				

Division of Health Service Regulation

STATE FORM BEF911 If continuation sheet 3 of 10

Division of	of Health Service Regu	lation				
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
						_
		MUI 000 000	B. WING		R	
		MHL080-222	B. W		02/0	14/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
		523 NOR	TH LONG STRE	ET		
REVIVE H	OUSING, LLC	SALISBU	IRY, NC 28144			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	NI	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
V 293	Continued From page	<u> </u>	V 293			
	Continued From page		1 200			
	and [Client #1]. In the	phone conversation with				
	the employee, she in	dicated that her cell phone				
	was taken by the clie	nt who then proceeded to				
	toss her outside the h	nome and punch her in the				
	face because he was	asked to use dish detergent				
	to ensure there were	no greasy dishes. The				
	employee was asked	if anyone was harmed of				
	which the employee a	advised that she had a				
	busted lip and a bum	p on her head. She was				
	asked if the client was	s harmed of which she				
	advised he was not.	The employee was asked if				
	she needed medical	care to the home of which				
	she indicated she did	not. [QP/RN] reviewed the				
	camera while on the	phone with the staff of which				
	the camera did not ha	ave a recording of the said				
	incident. The house of	director [Director] was also				
	notified while on the p	phone with the employee				
	who went to the home	e to investigate the issue.				
	[QP/RN] stayed on th	e phone with the employee				
	until [Director] arrived	I at the home. After further				
	investigation [Client #	[‡] 1] was not the aggressor in				
	this incident although	it could have been				
	de-escalated by staff.	. Not saying [Client #1] was				
	right to react in a phy-	sical manner. Staff said she				
	"brushed up against [Client #1] body as she was				
	trying to get by him w	hile standing in the kitchen.				
	[Client #1] stated that	t staff was antagonizing him				
	and yelling while pusl	hing her cell phone near his				
	face. [Client #1] snato	ched her cell phone and				
	stepped back away fr	om staff. Staff then				
	proceeded to get her	phone back and they began				
	to wrestle in the hallw	ay by the back door. [Client				
	#1] stated that staff h	ad bit him on his right hand.				
	As a result, he said h	e punched staff and threw				
	her down the stairs. [Client #1] has refused to get			ľ	
	injury looked at by me	edical professionals. All			ľ	
	, , ,	tified within the 24hr time				
	frame pending interna	al and external investigation			ľ	
	to this matter."	-				

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-"All employees are slated to go through

STATE FORM 6899 BEF911 If continuation sheet 4 of 10

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
ANDILAN	or contribution	BENTI TOATION NOMBER.	A. BUILDING: _	A. BUILDING:		-125
					R	
		MHL080-222	B. WING		02/0	4/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		523 NORTI	H LONG STRE	ET		
REVIVE H	OUSING, LLC	SALISBUR	Y, NC 28144			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DATE
				52.18.2.16.7		
V 293	Continued From page	e 4	V 293			
	additional ERDI trainir	ng on. This training will also				
		echniques and scenarios. As				
		at the involved employee				
		paid leave until investigation				
		nally, all staff will participate				
		as part of a requirement for				
	•	nt at Revive Housing, LLC.				
		(1)] was informed that her				
	employment with Rev	ive Housing, LLC is being				
	terminated, 12-10-21.	"				
	•	police report for incident				
	dated 11-20-21 revea					
		Former Staff #1] and juvenile				
		physical altercation. Neither				
	parties wanted to pres					
	-	scene and stated that the				
	video footage of the a reviewed."	mercation would be				
	reviewed.					
	Review on 2-1-22 of i	nformation from the Mayo				
	clinic's website dated					
	-"To take care of	a human bite that breaks the				
	skin:seek emergend	cy medical care."				
		an injury assessment report				
	dated 11-21-21 and s	igned by the QP/RN				
	revealed:					
	-	ent of the client at				
		n the day of the incident by				
	• •	d a visible bite mark to the ssessment there was visible				
		ssessment there was visible as well as broken skin.				
		g or blood present at the				
		nt. Ointment had been				
		staff member prior to the				
	• • • • • • • • • • • • • • • • • • • •	n the assessment the client				
		l like to be taken for medical				
		declined. No medical				
	emergency was prese					

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STATE FORM BEF911 If continuation sheet 5 of 10

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
MHL080-222		B. WING		R 02/04/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E ZIP CODE	
			TH LONG STREE		
REVIVE H	IOUSING, LLC		RY, NC 28144	•	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 293	Continued From page	: 5	V 293		
		N, BSN (Bachelor of Science ster of Science in Nursing)."			
	mark on Client #1's rig bite mark from incider -Several areas of	ndated of picture of bite ght hand labeled [Client #1] ht 11-20-21 revealed: broken skin in a half circle. n, raised, and reddened			
	Review on 1-13-22 of progress note dated 11-21-21 written by Staff #2 revealed: -"Upon arrival, staff asked client (Client #1) if he would like to go to the doctor for the incident that happened last night, client refused again, stating he is OK."				
	again asked client if h				
	that he sustained on mark on the hand how were no signs of infectivas asked again if he of which he declined. my asking as he indict he has advised that he will let someone krashift staff who communications.	e QP/RN revealed: the bite mark to his hand 11/21. There is still a visible vever site was clear, there stion or swelling. [Client #1] needed medical treatment He was a bit frustrated with ated staff keeps asking and e is OK and if that changes now. Communicated with on inicated that ointment had as advised to continue to cate should any concerns by [Client #1] directly."			

Division of Health Service Regulation

STATE FORM BEF911 If continuation sheet 6 of 10

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		MHL080-222	B. WING		1	4/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
			I LONG STRE			
REVIVE H	OUSING, LLC		Y, NC 28144			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				22.16.2.16.17		
V 293	Continued From page	e 6	V 293			
	Interview and observa	ation on 1-5-22 with Client				
	#1 revealed:	aden en 1 e 22 mai enem				
		Staff #1 (FS#1) had an				
		d inside the facility until he				
	took her outside and	pushed her off the steps.				
	-He was about to	turn around.				
		e. I put my hand out and she				
	•	ed holding his right hand				
	straight out.)					
		d out (of her mouth) and hit				
	her in the face about					
		n the house and locked the				
	door."	ccidentally run into his hand,				
		she had her teeth in me."				
	Sile Was looked on, c	one had her teeth in me.				
	Interview on 1-5-22 w	vith Client #2 revealed:				
	-"She (FS#1) gra	bbed him, she bit him, he				
	punched her."					
	Interview on 1-10-22	with Former Staff #1				
	revealed:					
		the had bitten Client #1; "I				
		lled me, she called me and				
	•	nas bite marks but that could nis can't be on mythat's				
		elling her I don't know what				
		t I didn't attack him. I				
		n. That could have come				
		s he threw. Me outright biting				
		or one, first and foremost,				
		off, no, for one I'm smaller				
	-	and I have a metal rod in my				
		ying to remember to keep				
		trying to make sure you				
	•	nd I'm trying to get to my				
	phone before he brok	e it."				
	Interview co. 4.5.00					
	interview on 1-5-22 a	nd 1-20-22 with Staff #2				

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STATE FORM BEF911 If continuation sheet 7 of 10

DIVIDION	n nealth Service Negu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			B. WING		R	
		MHL080-222	B. WING		02/04/2	2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		523 NORT	H LONG STRE	ET.		
REVIVE H	OUSING, LLC		RY, NC 28144			
			1, 140 20144	T		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
			PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
	TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			DEFICIENCY)		
		_	1,,,,,,,			
V 293	Continued From page	27	V 293			
	revealed:					
	-He had been wo	orking that shift with Former				
		ue to a personal medical				
	emergency approxima	•				
		ack (to the facility) that's				
	when I came on her (
		me she (FS#1) bit him. I saw				
		Il sat down with [Director],				
		ne admitted she bit him."				
	[•, .]					
	Interview on 1-7-22 with Staff #3 revealed:					
	-"I don't know no	thing. I just know he had				
		a bite mark on his hand.				
	[Staff #2] got here the	ey had got into an argument				
		at she (FS#1) pushed him				
	out of the way and tha	, , ,				
	Interview on 1-7-22 w	ith the Director revealed:				
	-They had repeat	tedly asked him on the day				
		anted to go to the doctor,				
	but he refused.	,				
	Interview on 1-25-22	with the QP/RN revealed:				
	-She is a Registe	ered Nurse.				
	_	ated that he didn't need				
	medical care.					
	-When she exam	nined the bite mark that day				
		red, but was not bleeding.				
		it was an emergency."				
		applied by staff prior to me				
	getting there. It looked					
		ain if he wanted to get care				
	and he said no."	5				
	-She told staff to	watch for signs of redness				
	or swelling.	3				
	_	ility often and rechecked the				
	bite mark.	•				
		sure to document that he				
	had repeatedly refuse					

Division of Health Service Regulation

STATE FORM BEF911 If continuation sheet 8 of 10

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL080-222	B. WING		R 02/04/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
REVIVE H	OUSING, LLC		H LONG STRE Y, NC 28144	ET		
	OLIMANA DV. OT		1	DDOVIDEDIO DI AN OF CODDECTIO		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 293	Continued From page	8	V 293			
	2-2-22 and signed by	Plan of Protection dated the Qualified red Nurse (RN, BSN, MSN)				
	ensure the consumer "Revive housing will in protocol that will inclus medical care if injury medical care. This will client's refusal to seel Employees will be see communications and change in the protocol	mmediately update injury de taking clients to seek is sustained that warrants Il happen regardless of				
	happens. "[Director], and [Asso the electronic commu 2022 with required ele staff have received co communicate verbal u February 4th house n Professional] and [Dir records are documen					
	Staff #1 on 11-20-21. of broken skin in a ha broken, raised, and re Although he was offer standard treatment for medical attention from infection. The QP/RN services to ensure that	human bite from Former The bite was several areas If circle. The skin was puffy, eddened around bite marks. red medical treatment, r a human bite includes n a doctor, due to the risk of failed to coordinate at Client #1 received medical tan bite. This deficiency				

Division of Health Service Regulation

STATE FORM BEF911 If continuation sheet 9 of 10

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED			
		MHL080-222	B. WING		02	R 2/ 04/2022		
NAME OF PROVIDER OR SUF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
REVIVE HOUSING, LLC			TH LONG STRE	ET				
PREFIX (EACH	DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE		
detrimental t the clients. If 45 days, and day will be in	Type B o the hea the viola administ	Rule violation which is alth, safety and welfare of ation is not corrected within rative penalty of 200.00 per or each day the facility is out d the 45th day.	V 293					

Division of Health Service Regulation

STATE FORM BEF911 If continuation sheet 10 of 10