STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL047-103	A. BUILDING: _____ B. WING _____	C 03/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HOUSE	1892 TURNPIKE ROAD RAEFORD, NC 28376

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V 000	INITIAL COMMENTS A complaint survey was completed on March 7, 2022. The complaints were substantiated (intake #NC00186698, #NC00186741). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 PRTF-Psychiatric Treatment Facility for Children and Adolescents. The survey sample consisted of audits of 6 current clients.	V 000		
V 314	27G .1901 Psych Res. Tx. Facility - Scope 10A NCAC 27G .1901 SCOPE (a) The rules in this Section apply to psychiatric residential treatment facilities (PRTF)s. (b) A PRTF is one that provides care for children or adolescents who have mental illness or substance abuse/dependency in a non-acute inpatient setting. (c) The PRTF shall provide a structured living environment for children or adolescents who do not meet criteria for acute inpatient care, but do require supervision and specialized interventions on a 24-hour basis. (d) Therapeutic interventions shall address functional deficits associated with the child or adolescent's diagnosis and include psychiatric treatment and specialized substance abuse and mental health therapeutic care. These therapeutic interventions and services shall be designed to address the treatment needs necessary to facilitate a move to a less intensive community setting. (e) The PRTF shall serve children or adolescents for whom removal from home or a community-based residential setting is essential	V 314		

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V 314	Continued From page 1 to facilitate treatment. (f) The PRTF shall coordinate with other individuals and agencies within the child or adolescent's catchment area. (g) The PRTF shall be accredited through one of the following; Joint Commission on Accreditation of Healthcare Organizations; the Commission on Accreditation of Rehabilitation Facilities; the Council on. Accreditation or other national accrediting bodies as set forth in the Division of Medical Assistance Clinical Policy Number 8D-1, Psychiatric Residential Treatment Facility, including subsequent amendments and editions. A copy of Clinical Policy Number 8D-1 is available at no cost from the Division of Medical Assistance website at http://www.dhhs.state.nc.us/dma/. This Rule is not met as evidenced by: Based on interviews and records review, the facility failed to provide required supervision and specialized interventions to ensure the safety of clients on a 24-hour basis affecting 4 of 6 audited clients (#1 #2 #3 and #4). The findings are: Review on 3/7/22 of Client #1's record revealed: -A 13 year old male. -Admission date of 2/12/20. -Diagnoses of Bipolar Disorder, Current Episode Manic Severe with Psychotic Features; Adjustment Disorder with Anxiety; Other Persistent Mood Disorders (Affective.) Review on 3/7/22 of Client #2's record revealed: -An 11 year old male.	V 314		

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V 314	Continued From page 2 -Admission date of 12/2/21. -Diagnoses of Other persistent mood [affective] disorders; Conduct disorder, childhood-onset type; Borderline Intellectual Functioning; Child neglect or abandonment, confirmed, initial encounter. Review on 3/7/22 of Client #3's record revealed: -A 17 year old male. -Admission date of 5/8/20. -Diagnoses of Disruptive Mood Dysregulation Disorder; Conduct Disorder, Unspecified Disruptive Impulse Control and Conduct Disorder; Post Traumatic Stress Disorder; Attention Deficit Hyperactivity Disorder, Combined Presentation per History; Cannabis Use Disorder, Mild; Child Neglect (per history). Review on 3/7/22 of Client #4's record revealed: -A 13 year old male. -Admission date of 2/3/21. -Diagnoses of Conduct Disorder, Childhood Onset Type; Disruptive Mood Dysregulation Disorder; Attention Deficit Hyperactivity Disorder, Combined Presentation; Child Physical Abuse (per history); Child Neglect (per history). Review on 3/7/22 of the Facility's Incident Reports revealed: -Incident report for Client #1: -Incident dated 2/22/22. -Report completed by the Nurse. -"Client was given a urine drug test. Client was positive for Tetrahydrocannabinol (THC.)" -Incident report for Client #2: -Incident dated 2/22/22. -Report completed by the Nurse. -"Client was given a urine drug screen. Client had a weak positive for THC." -Incident report for Client #3:	V 314		

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V 314	Continued From page 3 -Incident dated 2/22/22. -Report completed by the Nurse. -"Room searches were conducted and due to paraphernalia being found in a client's room (vaping pen,) drug tests were done. Client was given a drug test and was positive for THC." -Incident report for Client #4: -Incident dated 2/22/22. -Report completed by the Nurse. -"Room searches were conducted and paraphernalia was found in a client's room (vaping pen.)Due to this, Urine Drug Screens were done. -"Client was given a urine drug screen. Client was positive for THC." Interview on 3/7/22 with Client #1 revealed: -Regarding the vaping pen: -He did not know where the vaping pen came from. -He just knew that Client #3 had it with him. -He believed that it came from Client #3's home or that he brought it in from his home visit. -He acknowledged vaping. -He acknowledged being positive for marijuana after being tested. -Regarding when and where the vaping occurred: -He reported that it was perhaps around noon one day. -He had gotten the pen and did "a couple of hit" in the hallway by the rooms. -Reported that staff was not around in the hallway at the time. Interview on 3/7/22 with Client #2 revealed: -Regarding incident with vaping pen: -He did not wish to share who gave him the vaping pen nor how he received it. -Acknowledged testing positive for THC. -Did not wish to talk about the incident any	V 314		

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V 314	Continued From page 4 further. Interview on 3/7/22 with Client #3 revealed: -Regarding incident with vaping pen: -Client #3 denied bringing the vaping pen to the facility. -He acknowledged doing drugs when he was out on his day pass for home visit and that it was just a coincidence that there was a vaping pen at the center afterwards. -He was tested for drugs and came out positive for THC. -Reported not knowing where the pen came from. Interview on 3/7/22 with Client #4 revealed: -Regarding incident with vaping pen: -Client #4 acknowledged vaping at the facility. -Reported that the vaping pen belonged to Client #3. -Client #3 had brought it from his home. -Client #4 was drug tested and came out positive for THC. -Regarding time and place of when the vaping occurred: -Client #4 reported of not remembering when nor where the vaping occurred. Interview on 3/7/22 with the Local Management Entity staff revealed: -She had received telephone call from Client #2's mother with information about her son at the facility. -Client #2's mother reported that she had not received her usual telephone call from her son on Tuesday, February 22, 2022, and when she called the agency, she was told that her son had lost his privilege of using the phone after he tested positive for marijuana. -Mother further informed that she was able to talk	V 314		

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V 314	Continued From page 5	V 314		

to her son later and he informed her that another child had brought in the vaping pen from his home visit.
-Mother was concerned about kids not being supervised properly and being able to vape.

Interview on 3/7/22 with Staff #7 revealed:
-She was a Residential Mentor.
-Had been working at facility for about 2 months.
-She was aware about the incident with the vaping pen and kids testing positive for drugs.
-She denied ever smelling anything.
-"Kids did not tell anything until after it came out. They started to say who had brought the pen in. They also did not say where they did it."
-"Staff does not really know what the clients do inside their rooms. During 3rd shift, staff are out in the hallways and kids are sleeping in their rooms. Staff walks the halls."
-She had never heard of any staff ever smelling anything weird at the center.
-It was never found out exactly when or where in the facility the clients had done the vaping.

Interview on 3/7/22 with Staff #8 revealed:
-Worked as a Residential Mentor
-Had been working since December 2021.
-He worked 1st shift.
-He denied ever smelling anything in the halls or bathrooms.
-He was shocked to learn about the incident when it occurred.
-He believed that the incident occurred during the night.
-He did not know when exactly.
-He always worked first shift.
-He did not think the vaping pen was ever found.

Interview on 3/7/22 with the Executive Director revealed:

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V 314	Continued From page 6 -Reported that Child Protective Services (CPS) had recently conducted an investigation at the center. -CPS investigated due to allegation of clients testing positive for THC. -"What prompted the urine drug test was that one day while center was doing its daily room searches for contraband, one of the staff found a powdery substance inside a zip lock bag." -"It was unknown what the substance was or how it came inside." -"Nurse, Physician and Director were informed and they requested for children to be drug tested." -"Not all kids were tested. Only the kids that hung around together from where the substance was found." -"In addition, one of the kids informed that another kid had a vaping pen." She conducted an informal investigation. -"It was determined that the vaping pen was brought in by [Client #3.] -"[Client #3] had approved home visits as he was getting ready to transition." -"While kids were being investigated, one of the kids informed that Client #3 had brought the vaping pen in." -"When they asked Client #3 to do the urine drug screen, he came out and said that he was dirty as he acknowledged doing drugs while out on his home visit." -"He denied bringing the vaping pen to the facility." -"Once the other kids tested positive, a couple of them told on [Client #3] and said that he had brought in the pen." -Protocol for when clients returned from home visits was for them to be patted down by the staff and asked to remove their shoes. -New updated protocol was put in place after the	V 314		

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V 314	Continued From page 7 recent incident of the vaping pen being brought in. -She believed that the kids that vaped may have done it in the bathroom. -"They would ask to go to the bathroom or to go take a shower." -"Staff does not go inside the bathroom with them. They had no way of seeing anything." -"Staff also denied ever smelling anything, plus they wear their masks, further preventing them from smelling things." -One of the kids also told her that he did it in the bathroom. -[Client #3] would go home during the day and return to the facility in the afternoon. -He would do it for Friday, Saturday and Sunday. -After his most recent home visit. He returned to the facility on a Sunday. Kids were then tested on a Tuesday after that Sunday. -No staff came to her stating that they had smelled anything. -She had never smelled anything. -If staff would have ever smelled anything, they needed to have it reported to her. -Search occurred during 1st shift. -Drug test occurred during 1st shift. -She acknowledged that Clients #1, #2, #3 and #4 had tested positive for THC while being at the facility. Interview on 3/7/22 with the Director of Operations revealed: -He was aware that a client at the facility had brought in a vaping pen with marijuana concentrate and that it was shared with three other clients. -All four clients tested positive for marijuana. -He updated the agency's policy for "off campus visits, outings, on campus visitation, room searches and incident reporting."	V 314		

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V 314	Continued From page 8 -He denied having done anything regarding client's supervision at the agency. -He acknowledged that Clients #1, #2, #3 and #4 were able to vape while inside the facility and later tested positive for marijuana. Review on 3/7/22 of the Plan of Protection dated 3/7/22 written by the Director of Operations revealed: "What immediate actions will the facility take to ensure the safety of the consumers in your care? -Clients must be supervised (within eye distance) at all times. -No more than 4-clients should be under the direct supervision of one staff. -At no time should a staff member be alone with clients. -When a client is in their room, bathroom, or on the hallway, at least two staff must be present to supervise the hallway. -Staff will 'walk the beat' to ensure proper coverage on the Residential Hall. -During the awake hours, the "walk the beat" function is continuous. -Two staff must be in the recreation area (outside) when at least one client is present. -Client room doors will remain open at all times. -Staff should remain on Residential Hall when a client is using the bathroom. -Staff should pay special attention for unusual noises or an excessive amount of time spent in the bathroom by the client. -A visual inspection must be conducted before another client is allowed to enter the bathroom. -Clients will be searched by two male staff when returning from out of facility activities. -The appropriate incident report will be completed.	V 314		

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V 314	Continued From page 9 -In addition, magnetic check points will be installed in the near future which must be activated every 15 minutes to ensure that staff are monitoring continuously. Describe your plans to make sure the above happens. -Staff would be monitored by the Executive Director. -Videos from the facility would be monitored by the Director of Operations. -Failure to follow these policies will result in a disciplinary warning which could lead to suspension or separation from the company. " Clients ranged in ages from 11-17 with diagnoses of Bipolar Disorder, Adjustment Disorder with Anxiety, Persistent Mood Disorder (Affective,) Conduct disorder, Childhood-Onset type, Borderline Intellectual Functioning; Child Neglect or Abandonment; Disruptive Mood Dysregulation Disorder, Unspecified Disruptive Impulse Control, Post Traumatic Stress Disorder , Attention Deficit Hyperactivity Disorder, Cannabis Use Disorder, Child Physical Abuse. The facility staff failed to provide ongoing supervision. This lack of supervision resulted in Clients #1, #2, #3 and #4 being able to vape marijuana concentrate inside the facility. According to interviews, Client #3 had gone on home visits on the weekend and brought in the vaping pen with him. Client #3 shared the vaping pen with Clients #1, #2 and #4. Clients were able to vape while there were no staff around them. Clients vaped in the hallways and bathrooms. During daily room searches for contraband, drug paraphernalia had been found inside one of the client's bedrooms. Concerned treatment staff ordered the clients to be tested for substances. Clients #1, #2, #3 and #4 tested positive for Tetrahydrocannabinol (THC.) Clients	V 314		

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V 314	Continued From page 10 #1, #2 and #4 acknowledged testing positive for THC after vaping inside the facility. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $1500 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 314		