

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SPRUCE COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6200-E THERMAL ROAD CHARLOTTE, NC 28211
---	---

(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	<p>INITIAL COMMENTS</p> <p>A complaint survey was completed on April 29, 2022. The complaints were unsubstantiated (Intake #NC00187849 and NC00187857). Deficiencies were cited.</p> <p>The facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents.</p> <p>The facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 2 current clients and 1 former client.</p>	V 000		
V 131	<p>G.S. 131E-256 (D2) HCPR - Prior Employment Verification</p> <p>G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility failed to access the Health Care Personnel Registry (HCPR) prior to an offer of employment affecting 1 of 2 audited former staff (Former Staff #3). The findings are:</p> <p>Review on 4/18/22 and 4/19/22 of Former Staff</p>	V 131		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SPRUCE COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6200-E THERMAL ROAD CHARLOTTE, NC 28211
---	---

(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 131	Continued From page 1 #3 (FS#3)'s record revealed: -Hired 5/24/21; -Separated 4/8/22; -Employed as Behavioral Health Counselor; -HCPR check completed 8/26/21. Interview on 4/19/22 with the Executive Director revealed: -Will discuss the late HCPR check for FS#3 with Human Resources as they were responsible for completing the HCPR checks.	V 131		
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 to facilitate treatment.	V 314		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SPRUCE COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6200-E THERMAL ROAD CHARLOTTE, NC 28211
---	---

(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 314	<p>Continued From page 2</p> <p>(f) The PRTF shall coordinate with other individuals and agencies within the child or adolescent's catchment area.</p> <p>(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/.</p> <p>This Rule is not met as evidenced by: Based on interview, record review, and observation, the facility failed to provide a structured living environment to address functional deficits, therapeutic interventions, and services to address the treatment needs of the children affecting 2 of 2 audited current clients (Clients #1, and #2) and 1 of 1 audited former client (Former Client #3). The findings are:</p> <p>CROSS REFERENCE: 10A NCAC 27G .1902 Staff (V315) Based on interview, record review, and observation the facility failed to ensure at least two direct care staff members were present for every six children.</p> <p>Review on 4/18/22 of the facility's Incident</p>	V 314		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SPRUCE COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6200-E THERMAL ROAD CHARLOTTE, NC 28211
---	---

(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 314	<p>Continued From page 3</p> <p>Reports dated 3/1/22 to 4/18/22 revealed: -Report dated 3/8/22 regarding an incident on 3/5/22 involving Client #1 " ...engaging in inappropriate sexual acts with a peer (Former Client #3 - FC#3) in the form of kissing, hugging, and touching each other inappropriately ...kissed behind the tree ...Staff responded by calling the supervisor and separating the two girls into different cottages for a short period of time. Staff kept client and her peer separated for the remainder of the evening ...;" -Report dated 3/15/22 regarding an incident on 3/14/22 involving Client #1 when another female client complained Client #1 " ...was bending over in the locker room area without clothes on asking for other to look at her ...;" -Report dated 4/1/22 regarding an incident on 3/27/22 involving Client #1 and FC#3 when FC#3 voluntarily reported to staff that over the weekend Client #1 and FC#3 " ...were displaying inappropriate behaviors toward each other ... [Client #1] touched her (FC#3)'s private area and her breasts while playing on the playground ...were behind a tree when [Client #1] pulled down [FC#3]'s pants and began to play 'boyfriend and girlfriend'[FC#3] also stated that [Client #1] touched her and licked her when after she (Client #1) pulled [FC#3]'s pants down ...also reported that [Client #1] kissed her ...;" -Report dated 4/10/22 regarding an incident on 4/8/22 when " ...[FC#3] at the door of one of her peers (Client #1). Staff informed client that she is never allowed to be in the room of another peer or at the door and asked why she went over there, and client would not respond ...at no time did she respond other than shrugging her shoulders ...;" -Report dated 4/11/22 regarding an incident on 4/11/22 when FC#3 " ...made sexual inappropriate gestures while in her doorway ..."</p>	V 314		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SPRUCE COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6200-E THERMAL ROAD CHARLOTTE, NC 28211
---	---

(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 314	<p>Continued From page 4</p> <p>Review on 4/18/22 of Client #1's record revealed: -Admitted 4/21/21; -Diagnosed with Post-Traumatic Stress Disorder, Reactive Attachment Disorder, Mild Intellectual Developmental Disability, Myasthenia Gravis without Exacerbation; -10 years old.</p> <p>Review on 4/19/22 of Client #1's Safety Plan dated 3/31/22 sent via email correspondence to the treatment team and nursing staff on 3/31/22 at 2:23pm from Client #1's therapist revealed: -"Classroom/Cottage Procedures: (1) In the cottage, and if possible, move to a room that is hard for other clients to view and easy for staff for view. If this is not possible make sure it is easy to view for staff (no shared rooms - no exceptions) (a) Only staff and the particular client allowed in room and not allowed in other client's rooms (b) A space should be kept between child and peer when sitting on the couch or other conjoined seating area (c) Absolutely no sharing items (such as personal items or food) (d) Not able to do special events, where the client would be in a different cottage, such as going to someone discharge party etc ...(e) If transporting with other clients, preferential seating close to staff. (2) Child should be monitored around all children at all times (If you cannot see [Client #1] she is not close enough to you. She should NEVER be alone with another peer) This means on the playground as well. (3) Monitored when using an electronic (i.e. next to staff) (4) No sexual play, sexual touching, or anything that might be interpreted as sexual play or touching including playing doctor, nurse, house, or other games that have a hierarchy. (5) Only child in the bathroom (a) Including changing clothes for swimming. Changes in private (6) When in the academic</p>	V 314		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SPRUCE COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6200-E THERMAL ROAD CHARLOTTE, NC 28211
---	---

(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 314	<p>Continued From page 5</p> <p>setting, the class bathroom should not be used as a method to move from one classroom to the next (transition by all students and staff should be through the hallway). (a) The bathroom door should always remain closed and knock before entering (7) Wear appropriate clothing at all times (something over underwear). Change in private areas."</p> <p>Review on 4/18/22 of FC#3's record revealed: -Admitted 3/1/22; -Diagnosed with Oppositional Defiant Disorder, Reactive Attachment Disorder; -6 years old; -Discharged 4/15/22; -Possible victim of sexual abuse while residing in family home.</p> <p>Review on 4/18/22 and 4/19/22 of Former Staff #2's (FS#2) record revealed: -Hired 7/18/17; -Separated 4/8/22; -Employed as Behavioral Health Counselor (BHC).</p> <p>Review on 4/18/22 and 4/19/22 of Former Staff #3's (FS#3) record revealed: -Hired 5/24/21; -Separated 4/8/22; -Employed as Behavioral Health Counselor.</p> <p>Review on 4/21/22 of the facility's video surveillance of the living room/common area of the facility on 4/8/22 between approximately 6:58am and 7:20am revealed: -Start of the video revealed an adult figure laying on the couch with blankets; -Unable to determine if the adult figure was male or female but the figure had an electronic device; -Minimal lighting in the facility;</p>	V 314		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SPRUCE COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6200-E THERMAL ROAD CHARLOTTE, NC 28211
---	---

(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 314	<p>Continued From page 6</p> <ul style="list-style-type: none"> -Figure on the couch was the only visible adult; -3:06 into the video: Client #1 emerged from her bedroom, positioned herself at the dining table, and returned to her room at 4:00 into the video; -4:04 into video: Client #1 emerged from her bedroom, positioned herself at the dining table, and returned to her room at 5:02 into the video; -7:17 into the video: a figure emerged from FC#3's bedroom but the figure was too grainy to identify. The grainy figure moved toward the back of the couch toward the kitchenette and the video feed froze and then resumed feed at approximately 8:04 into the video when the grainy figure completely disappeared from the video without any smooth transition of where the grainy figure went; -12:10 into the video: adult and child voices can be heard; -15:16 through 15:25 into the video: the video jumped without a smooth transition of staff getting off the couch, but the staff was across the room from the couch when the video resumed at 15:25; -Two blankets were left on the couch after the adult figure moved from the couch after over 15 minutes into the video feed; -15:54 into the video: adults and children were present walking around the facility -The desk and chair remained empty with no staff working at the computer throughout the video footage; -There were several periods where video footage froze for up to 25 seconds at a time and other episodes of video jumping without a natural transition in movement throughout the video footage; -The last two minutes of the video footage was without audio recording with the two staff members at the dining table within close proximity of each and appeared to be engaged in conversation. 	V 314		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SPRUCE COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6200-E THERMAL ROAD CHARLOTTE, NC 28211
---	---

(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 314	<p>Continued From page 7</p> <p>Interview on 4/18/22 with Client #1 revealed: -Denied any sexualized touching or behaviors between her and other clients; -Did not want to discuss FC#3 at all because she "did not like her."</p> <p>Attempted interview on 4/18/22 with FC#3 was unsuccessful. FC#3 refused to be interviewed.</p> <p>Interview on 4/19/22 with FS#2 revealed: -First contact with FS#2 requesting an interview revealed FS#2 no longer worked at the facility and he did not wish to discuss anything to do with the facility; -Second contact with FS#2 five and one-half hours after the first contact was initiated by FS#2; -During the second contact, FS#2 revealed an incident occurred between Client #1 and FC#3 on the morning of 4/8/22; -FS#2 was sitting in the chair at the computer looking down completing his notes during the incident; -FS#2 looked up and saw FC#3 coming out of Client #1's bedroom; -Both Client #1 and FC#3 were smiling; -Cannot recall any other details about the incident except FS#3 was coming out of the restroom; -FS#2 did not question Client #1 or FC#3 regarding what happened but continued completing his notes.</p> <p>Interview on 4/19/22 with FS#3 revealed: -Resigned from the facility after being suspended due to an incident involving Client #1 and FC#3; -Client #1 and FC#3 woke up first in the facility; -FS#3 disarmed Client #1's bedroom door alarm so Client #1 could use the bathroom; -FS#3 was upset at FS#2 because FS#2 was on the couch and not helping with chores;</p>	V 314		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SPRUCE COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6200-E THERMAL ROAD CHARLOTTE, NC 28211
---	---

(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 314	<p>Continued From page 8</p> <ul style="list-style-type: none"> -FS#3 got cleaning supplies and started morning cleaning chores and laundry; -FS#3 instructed FS#2 to watch Client #1 and FC#3 while FS#3 cleaned; -FS#3 came out from cleaning the bathroom and observed FC#3 at Client #1's bedroom door and FC#3 was holding something in her hands; -FS#3 investigated what was in FC#3's hands and discovered FC#3 was holding her shorts and was no longer wearing the shorts; -FS#3 questioned FS#2 and FS#2 denied knowing what had happened; -FS#3 told FS#2 the incident needed to be reported and FS#2 said he did not know what happened and did not see anything when he was sitting on the couch; -FS#3 believed FS#2 was sleeping when the incident happened and that is why he did not witness anything between Client #1 and FC#3; -FS#3 reported the incident to her supervisor. <p>Interview on 4/18/22 and 4/19/22 with the Executive Director revealed:</p> <ul style="list-style-type: none"> -FS#2 and FS#3 were suspended pending an investigation as a result of the incident between Client #1 and FC#3 on 4/8/22; -FS#2 and FS#3 resigned after being suspended; -A safety plan for Client #1 was developed and implemented on 3/31/22; -All staff received notification of Client #1's safety plan on 3/31/22 via email correspondence; -A red flashing alert was added to Client #1's electronic record indicating Client #1 was on safety precautions for high likelihood of sexually inappropriate behavior; -FC#3 was moved from the facility and placed in a sister facility on 4/15/22. <p>Observation on 4/20/22 at approximately 11:30am of the facility and Interview with the</p>	V 314		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2022
NAME OF PROVIDER OR SUPPLIER SPRUCE COTTAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6200-E THERMAL ROAD CHARLOTTE, NC 28211		
(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 314	<p>Continued From page 9</p> <p>Executive Director revealed: -Entryway led to a hallway which led directly to a common area/living room. The common area/living fed into six client bedrooms and two common bathrooms. On the interior wall of the common area/living room was a kitchenette. A dining table and chairs were in front of the wall housing the kitchenette. In front of the dining table and chairs was a desk and office chair combination with a couch directly in front of the desk and chair. A computer was on the desk. There was room to allow clients and staff to walk between the dining table and the desk. During the observation of the facility, the Executive Director revealed Client #1 and FC#3 were housed in corner bedrooms diagonally across from each other.</p> <p>Review on 4/21/22 of the Plan of Protection written by the Executive Director dated 4/21/22 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? The two staff members that were working during the reported allegation are no longer employed by the agency. Of the two consumers involved in the reported allegation, one has been transferred to a different cottage - consumers no longer reside in the same building. The therapist of both consumers involved in the allegation has completed a safety plan that has been shared with all Behavioral Health Counselors (BHC). The PRTF (Psychiatric Residential Treatment Facility) Program Supervisors will re-train staff on the following agency policies, rules, and expectations: " BHC staff per AYN (Alexander Youth Network - Licensee) policy will remain awake at all times</p>	V 314		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SPRUCE COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6200-E THERMAL ROAD CHARLOTTE, NC 28211
---	---

(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 314	<p>Continued From page 10</p> <p>regardless of shift. All assigned staff will be awake, as there are no BHCs designated as "sleep staff".</p> <p>" BHC staff will not be permitted to bring blankets, pillows, and other bedding for their shift. The use of cottage linen will not be allowed.</p> <p>" PRTF Program Supervisors and management will conduct routine observations via in person or video surveillance 3x per week. The Executive Director will re-train program supervisors on the following policies: ratio, scheduling, supervision, and attendance. The program supervisors will re-train Behavior Health Counselors on the following policies: ratio, supervision, and attendance. PRTF supervisors will also review general work rules with BHCs to include: all cottages must have 2 staff at all times (no leaving to go to personal vehicle, cafeteria for personal needs) and BHCs must utilize walkie talkie devices to request support staff assistance prior to leaving out of the cottage. The PRTF supervisor for each shift will confirm verbally or face to face that each cottage is sufficiently staffed. Additionally, PRTF supervisors will verify that cottage coverage and OnShift scheduling are consistent. PRTF supervisors will update OnShift daily to reflect any changes within the scheduling (ie sick staff, staff cottage switch, etc). If a PRTF supervisor identifies that a cottage is not sufficiently covered, then the PRTF supervisor will provide coverage, until additional staff can arrive on campus.</p> <p>Describe your plans to make sure the above happens. Alexander Youth Network is working with an external agency to install and implement GuardOne - which is a security compliance</p>	V 314		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SPRUCE COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6200-E THERMAL ROAD CHARLOTTE, NC 28211
---	---

(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 314	<p>Continued From page 11</p> <p>platform that allows for system tracking relative to observations and bed checks.</p> <p>PRTF Management will complete internal interviews and identify a Lead BHC for 3rd shift who will responsible for ensuring compliance with agency policy related to consumer supervision. The agency utilizes OnShift, which is a web-based staff scheduling and labor management software which is designed to assist the agency with addressing and managing staffing related concerns. The agency has identified a process issue with use of OnShift. Therefore, additional training to enhance PRTF management understanding of Onshift and improve staff ability to operate and navigate the OnShift system will take place by April 30, 2022. Effective use of the OnShift application will simplify scheduling and assist proactively identifying ratio concerns, so that it can be resolved immediately.</p> <p>The Executive Director will confirm the review of the above information with BHCs via review of individual and/or group supervisions.</p> <p>The PRTF supervisors will notify the Executive Director and Vice President of Residential Services when there is a lack of coverage. PRTF management will work with other AYN agency service lines to acquire additional staff to work in coverage.</p> <p>Additionally, Human Resources department has implemented continuous recruitment efforts. Furthermore, the training department is now facilitating orientation 2x per month to allow staff to get trained and onto the milieu in a more effective manner."</p> <p>Review on 4/22/22 of the Plan of Protection written by the Executive Director dated 4/22/22 revealed: "What immediate action will the facility take to</p>	V 314		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SPRUCE COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6200-E THERMAL ROAD CHARLOTTE, NC 28211
---	---

(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 314	<p>Continued From page 12</p> <p>ensure the safety of the consumers in your care? The two staff members that were working during the reported allegation are no longer employed by the agency as of 4/11/22.</p> <p>Of the two consumers involved in the reported allegation, one has been transferred to a different cottage - consumers no longer reside in the same building. This transfer took place on 4/15/22.</p> <p>The therapist of both consumers involved in the allegation has completed a safety plan that has been shared with all Behavioral Health Counselors. The plan was completed and shared on 3/31/22.</p> <p>The PRTF Program Supervisors will re-train staff on the following agency policies, rules, and expectations:</p> <p>" BHC staff per AYN policy will remain awake at all times regardless of shift. All assigned staff will be awake, as there are no BHCs designated as "sleep staff".</p> <p>" BHC staff will not be permitted to bring blankets, pillows, and other bedding for their shift. The use of cottage linen will not be allowed.</p> <p>" PRTF Program Supervisors and management will conduct routine observations via in person or video surveillance 3x per week. The training will take place no later than 5/2/22.</p> <p>The Executive Director will re-train program supervisors on the following policies: ratio, scheduling, supervision, and attendance. The training will take place no later than 5/2/22.</p> <p>The program supervisors will re-train Behavior Health Counselors on the following policies: ratio, supervision, and attendance. The training will take place no later than 5/2/22.</p> <p>PRTF supervisors will also review general work rules with BHCs to include: all cottages must have 2 staff at all times (no leaving to go to personal vehicle, cafeteria for personal needs) and BHCs must utilize walkie talkie devices to</p>	V 314		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SPRUCE COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6200-E THERMAL ROAD CHARLOTTE, NC 28211
---	---

(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 314	<p>Continued From page 13</p> <p>request support staff assistance prior to leaving out of the cottage.</p> <p>The PRTF supervisor for each shift will confirm verbally or face to face that each cottage is sufficiently staffed. Additionally, PRTF supervisors will verify that cottage coverage and OnShift scheduling are consistent. PRTF supervisors will update OnShift daily to reflect any changes within the scheduling (ie sick staff, staff cottage switch, etc).</p> <p>If a PRTF supervisor identifies that a cottage is not sufficiently covered, then the PRTF supervisor will provide coverage, until additional staff can arrive on campus.</p> <p>Describe your plans to make sure the above happens.</p> <p>Alexander Youth Network is working with an external agency to install and implement GuardOne - which is a security compliance platform that allows for system tracking relative to observations and bed checks.</p> <p>PRTF Management will complete internal interviews and identify a Lead BHC for 3rd shift who will responsible for ensuring compliance with agency policy related to consumer supervision. Interviews will take place no later than 5/8/22.</p> <p>The agency utilizes OnShift, which is a web-based staff scheduling and labor management software which is designed to assist the agency with addressing and managing staffing related concerns. The agency has identified a process issue with use of OnShift. Therefore, additional training to enhance PRTF management understanding of Onshift and improve staff ability to operate and navigate the OnShift system will take place by April 30, 2022. Effective use of the OnShift application will simplify scheduling and assist proactively identifying ratio concerns, so that it can be</p>	V 314		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SPRUCE COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6200-E THERMAL ROAD CHARLOTTE, NC 28211
---	---

(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 314	<p>Continued From page 14</p> <p>resolved immediately.</p> <p>The Executive Director will confirm the review of the above information with BHCs via review of individual and/or group supervisions.</p> <p>The PRTF supervisors will notify the Executive Director and Vice President of Residential Services when there is a lack of coverage. PRTF management will work with other AYN agency service lines to acquire additional staff to work in coverage.</p> <p>Additionally, Human Resources department has implemented continuous recruitment efforts. Furthermore, the training department is now facilitating orientation 2x per month to allow staff to get trained and onto the milieu in a more effective manner."</p> <p>Clients #1, #2, and Former Client #3 (FC#3) were aged 6-11 years old and were diagnosed with mental health needs including, but not limited to, Post-Traumatic Stress Disorder, Reactive Attachment Disorder, Oppositional Defiant Disorder, and Attention Deficit Hyperactivity Disorder. Client #1 and FC#3 engaged in 5 incidents of inappropriate sexualized behaviors. The incidents occurred on 3/5/22 (Client #1 and FC#3 kissing, hugging, and touching), 3/14/22 (Client #1 bending over naked in the locker room exposing herself), 3/27/22 (Client #1 touching, fondling, and licking FC#3), 4/8/22 (FC#3 attempting to gain access to Client #1's bedroom), and 4/11/22 (FC#3 making sexually inappropriate gestures). A safety plan outlining treatment strategies for Client #1 was developed on 3/31/22 after the first three incidents occurred. No safety plan outlining treatment strategies was developed for FC#3. Two additional incidents of inappropriate sexualized behavior occurred on 4/8/22 and 4/11/22 when Client #1 and FC#3 made inappropriate sexualized gestures from</p>	V 314		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SPRUCE COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6200-E THERMAL ROAD CHARLOTTE, NC 28211
---	---

(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 314	Continued From page 15 their bedroom doorways or attempted to enter each other's bedrooms. FC#3 was discharged from the facility to a sister facility on 4/15/22. On 4/17/22 Client #2 entered Client #3's bedroom and assaulted Client #1 while Staff #1 worked alone. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of \$1,000.00 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		
V 315	27G .1902 Psych. Res. Tx. Facility - Staff 10A NCAC 27G .1902 STAFF (a) Each facility shall be under the direction a physician board-eligible or certified in child psychiatry or a general psychiatrist with experience in the treatment of children and adolescents with mental illness. (b) At all times, at least two direct care staff members shall be present with every six children or adolescents in each residential unit. (c) If the PRTF is hospital based, staff shall be specifically assigned to this facility, with responsibilities separate from those performed on an acute medical unit or other residential units. (d) A psychiatrist shall provide weekly consultation to review medications with each child or adolescent admitted to the facility. (e) The PRTF shall provide 24 hour on-site coverage by a registered nurse.	V 315		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SPRUCE COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6200-E THERMAL ROAD CHARLOTTE, NC 28211
---	---

(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 315	<p>Continued From page 16</p> <p>This Rule is not met as evidenced by: Based on interview, record review, and observation, the facility failed to ensure at least two direct care staff members were present for every six children. The findings are:</p> <p>Observation on 4/18/22 at approximately 11:10am of Client #1 revealed: -Small wound on Client #1's lower left jaw approximately 1/2 to 1 inch long.</p> <p>Review on 4/18/22 of Client #1's record revealed: -Admitted 4/21/21; -Diagnosed with Post-Traumatic Stress Disorder, Reactive Attachment Disorder, Mild Intellectual Developmental Disability, Myasthenia Gravis without Exacerbation; -10 years old.</p> <p>Review on 4/18/22 of Client #2's record revealed: -Admitted 11/24/21; -Diagnosed with Post-Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder; -11 years old. -Comprehensive Clinical Assessment completed 11/5/21 revealed Client #2 struggled with anger management and had a history of assault.</p> <p>Review on 4/18/22 and 4/19/22 of Staff #1's record revealed: -Hired 8/16/21; -Employed as a Behavioral Health Counselor.</p> <p>Interview on 4/18/22 with Client #1 revealed: -Client #2 "hit me in the face;" -Staff #1 was working alone when Client #2 entered Client #1's bedroom on 4/17/22 and hit Client #1.</p>	V 315		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SPRUCE COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6200-E THERMAL ROAD CHARLOTTE, NC 28211
---	---

(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 315	<p>Continued From page 17</p> <p>Interview on 4/18/22 with Client #2 revealed: -Staff #1 was working alone on the evening of 4/17/22; -Staff #1 was standing at the front door of the cottage; -Client #2 "watched where [Staff #1] was at so he would not see me" going into Client #1's bedroom; -Client #2 hit Client #1 "on her head while she was asleep" because Client #1 had called Client #2 stupid earlier in the day; -Client #1 yelled and attracted the attention of Staff #1 and Staff #1 saw Client #2 leave Client #1's bedroom.</p> <p>Interview on 4/19/22 with Staff #1 revealed: -Client #2 went into Client #1's bedroom and hit her during 2nd shift on 4/17/22; -Clients #1 and #2 had been arguing most of the day; -Client #2 had been "unregulated" most of the day and had spent one-on-one time outside the cottage with a supervisor to help him regulate his behaviors; -Client #2 went into Client #1's bedroom and hit Client #1 upon Client #2's return to the cottage after spending time with the supervisor; -Staff #1 did not witness Client #2 enter Client #1's bedroom but did witness Client #2 exit Client #1's bedroom; -Worked alone on 2nd shift on 4/17/22; -Was the only time Staff #1 worked alone and believed there was no second staff because it was challenging to get staff to work on the Easter holiday.</p> <p>Interview on 4/19/22 with the Executive director revealed: -The facility had been having staffing issues and struggled to get staff to work on some shifts;</p>	V 315		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SPRUCE COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6200-E THERMAL ROAD CHARLOTTE, NC 28211
---	---

(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 315	<p>Continued From page 18</p> <p>-Will continually work with the Human Resources department to secure additional staffing for the facility;</p> <p>-Will ensure two staff each shift in the facility.</p> <p>This deficiency is cross referenced into 10A NCAC 27G .1901 Scope (V314) for a Type A1 rule violation and must be corrected within 23 days.</p>	V 315		