STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601482	A. BUILDING: _____ B. WING _____	06/10/2022

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CHRIST CHURCH COTTAGE THOMPSON CHILD & FA	6722 ST PETERS LANE MATTHEWS, NC 28105

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 6-10-22. The complaint was unsubstantiated (#NC00187960). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G 1800 Intensive Residential Treatment for Children or Adolescents. This facility is licensed for nine and currently has a census of four. The survey sample consisted of two current clients and one former client.	V 000		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against	V 132	V132- **CORRECTION:** 1. Program Supervisors will be responsible to ensure to notification happens to the Department and HCPR is completed immediately. **PREVENTION:** 1. Retraining on the IRIS and incident reporting guidelines that include allegations of physical and sexual abuse. 2. Program Supervisors retraining on any allegations of abuse warrants a IRIS report. 3. If a investigation report is completed then Program Supervisors and Directors will be looped into communication and reports. 4. All RCS staff are assigned boundaries training at the start of employment to be completed in our Relias LMS.	7/1/2022 7/30/22 7/30/22 7/6/22 7/30/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Hannah Dunham | Hannah Dunham, Chief Performance & Quality Officer | 7/7/2022

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V 132	Continued From page 1 a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the Department of all allegations against health care personnel. The findings are: Review on 5-27-22 of Level I incident report dated 4-5-22 revealed: -"The following information was gathered the vice president of residential services as well as the youth himself: -Sometime between 3/2-3/7- Conversation with staff [Staff #1] about being fat. This led to staff pulling up her shirt to show her stomach and also pulled her waistband to her pants. This completely shocked [Former Client #1 (FC#1)] and he was a bit confused about what happened.	V 132	V 132 continued **MONITORING**: 1. Program Supervisors will notify Directors of incidents and Directors will ensure IRIS Reports are completed according to regulations policy expectations. 2. Monthly Scorecard/Incident Review Committee Meetings that involve PQI and Program Leaders.	Ongoing Ongoing

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V 132	Continued From page 2 -[FC#1] asked another resident (Former Client #4) if he saw what happened and he stated that he did see the staff flashing [FC#1]. - A couple of days after the incident, [FC#1] attempted to gain an understanding about the incident with [Staff #1] and she told him she would know if he's lying if he can describe what her private area looks like. They continued to have a discussion about the visual state of her private area (waxed vs. unwaxed) and [FC#1] stated this 'threw him back' and he did not know how to handle the situation. [Staff #1] did state that if she did flash [FC#1], it was by accident. - [FC#1] also shared that other inappropriate comments were made as well. - On Friday, [FC#1] requested to talk to [Supervisor] about this situation. According to [FC#1], [Staff #6] told him that [Supervisor] had his notebook and had taken it from his room. He continued to want to talk to [Supervisor], but was unable to do so. -On Sunday, [Staff #1] attempted gain information from other staff members after learning about the allegation [FC#1] made... and [FC#1] and [Staff#1] then became participants in an inappropriate verbal argument, both crossing boundaries... -[FC#1] wishes to speak with [Supervisor] and for his voice to be heard about this situation. He also requests that he not be around [Staff#1]. - As reported from the VP (Vice President) of Residential Operations on 4/4/22, this matter has been addressed. Residential called DSS (Department of Social Services) to make a report of the allegation, created an incident report, completed an IRIS (Incident Response Improvement System), separated the accused staff member from [FC#1] and addressed this issue with all staff involved. - ...will complete an Incident report in Echo to	V 132		

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V 132	Continued From page 3 document this allegation and document Residential's report to the state-level IRIS and the DSS report regarding the allegation." Interview on 6-9-22 with the Quality Improvement Specialist revealed: -She thought that an IRIS report had been done. -She knew the allegations should have been reported to the Health Care Personnel Registry. -They would make sure in was done in the future. Interview on 6-9-22 with the Supervisor revealed: -The former Vice President of Residential Services had told her that he would handle the situation and put the report in IRIS. -She thought he would have reported it to the Health Care Personnel Registry.	V 132		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible	V 366	V 366- **CORRECTION:** 1. Director will review Incident Reporting Policy and IRIS Manual with Program Supervisors to aid in the understanding of reporting levels. 2. Program Supervisors and Directors will immediately notify PQI of incidents involving clients to complete an investigation. 3. Director will re-train on the expectation of incident response by re-viewing the Incident Debrief/Follow-up Checklist that helps provide steps to responding to an incident. **PREVENTION:** 1. Director will follow-up after incidents occur to ensure checklist has been followed by Program Supervisors.	7/30/22 Ongoing 7/30/22 Ongoing

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V 366	Continued From page 4 for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident	V 366	V 366- Continued **MONITORING:** 1. Director will utilize weekly supervisions of Program Supervisors to ensure compliance with prevention plan. 2. PQI and Programs Leaders will review incidents and response in Incident Review Committee	Ongoing Ongoing

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V 366	Continued From page 5 and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law.	V 366		

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V 366	Continued From page 6	V 366		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to implement corrective measures for incidents. The findings are:

Review on 6-11-22 of Former Client #1's (FC#1) record revealed:
-Admitted 10-21-21.
-17 years old.
-Diagnoses include: Disruptive Mood Dysregulation, Oppositional Defiance Disorder, Borderline Intellectual Functioning, Major Depressive Disorder.
-Assessment dated 12-16-21 revealed: "Previously reported paranoid ideation involving people attacking him or talking about him...Insight into his behavior is limited, judgement is impaired...spends considerable amount of time posturing for peers by speaking in a defiant and brazen manner to staff."

Review on 6-6-22 of Staff #1's record revealed:
-Hire date of 1-4-22.
-Trainings include: Therapeutic Crisis Intervention (TCI) 1-7-22, CARE (Child-Adult Relationship Enhancement) training 1-13-22, Client Rights 2-10-22, New Employee Orientation 1-10-22.

Review on 5-27-22 of Level I incident report dated 4-5-22 revealed:
-"The following information was gathered the vice president of residential services as well as the youth himself:
-Sometime between 3/2-3/7- Conversation with

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V 366	Continued From page 7 staff [Staff #1] about being fat. This led to staff pulling up her shirt to show her stomach and also pulled her waistband to her pants. This completely shocked [Former Client #1 (FC#1)] and he was a bit confused about what happened. -[FC#1] asked another resident (Former Client #4) if he saw what happened and he stated that he did see the staff flashing [FC#1]. - A couple of days after the incident, [FC#1] attempted to gain an understanding about the incident with [Staff #1] and she told him she would know if he ' s lying if he can describe what her private area looks like. They continued to have a discussion about the visual state of her private area (waxed vs. unwaxed) and [FC#1] stated this 'threw him back' and he did not know how to handle the situation. [Staff #1] did state that if she did flash [FC#1], it was by accident. - [FC#1] also shared that other inappropriate comments were made as well - On Friday, [FC#1] requested to talk to [Supervisor] about this situation. According to [FC#1], [Staff #6] told him that [Supervisor] had his notebook and had taken it from his room. He continued to want to talk to [Supervisor], but was unable to do so. -On Sunday, [Staff #1] attempted gain information from other staff members after learning about the allegation [FC#1] made... and [FC#1]and [Staff#1] then became participants in an inappropriate verbal argument, both crossing boundaries... -[FC#1] wishes to speak with [Supervisor] and for his voice to be heard about this situation. He also requests that he not be around [Staff#1]. - As reported from the VP (Vice President) of Residential Operations on 4/4/22, this matter has been addressed. Residential called DSS (Department of Social Services) to make a report of the allegation, created an incident report, completed an IRIS (Incident Response	V 366		

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V 366	Continued From page 8	V 366		

Improvement System), separated the accused staff member from [FC#1] and addressed this issue with all staff involved.
- ...will complete an Incident report in Echo to document this allegation and document Residential's report to the state-level IRIS and the DSS report regarding the allegation."

Review on 6-3-22 of an Internal Investigation dated 4-8-22 and signed by the Supervisor revealed:
-"There was no evidence to substantiate that the staff member exposed her private parts based on interviews conducted. There are some concerns with the staff members boundaries and the staff member is recommended to go through inappropriate boundaries training."

Interview on 6-2-22 with Staff #1 revealed:
-FC#1 had previously told her that she was being flirtatious with him. She reported this to her supervisor and was told to not be alone with him, which she complied with.
-She then came to work later and was told that FC#1 had accused her of sexual assault.
-Her supervisor then told her she shouldn't talk about personal issues with the clients.
-"I didn't know, I'm young."
-Later FC#1 went into crisis and said that "my boyfriend doesn't deserve me, trying to lock a black man up" referring to Staff #1.
-"He (FC#1) said I showed him my vagina."
-"I said let's run the cameras."
-She had not received any training in boundries, either before or after the incident.

Email dated 6-7-22 from the Quality Improvement Specialist reveled:
-"After conferring with the program team it was determined that staff member [Staff #1] did

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V 366	Continued From page 9 not receive the recommended training as a result of transition in leadership during the time of this investigation."	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that	V 367	V 367- **CORRECTION:** 1. Program Supervisors will be retrained on incident reporting guidelines and expectations to have reports completed within the 72 hrs time frame. 7/30/22 **PREVENTION:** 1. Director will follow-up after incidents occur to ensure checklist has been followed by Program Supervisors. Ongoing 2. PQI will complete an ongoing incident review of clients EHR to ensure all incident that require a IRIS report are completed and submitted prior to the 72 hour timeframe. Ongoing **MONITORING:** 1. Director will utilize weekly supervisions of Program Supervisors to ensure compliance with prevention plan. Ongoing 2. PQI and Programs Leaders will review incidents and response in Incident Review Committee/Scorecard Meetings. Ongoing	

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information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).
(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:
(1) medication errors that do not meet the definition of a level II or level III incident;
(2) restrictive interventions that do not meet the definition of a level II or level III incident;
(3) searches of a client or his living area;
(4) seizures of client property or property in the possession of a client;
(5) the total number of level II and level III

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V 367	Continued From page 11 incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure that all Level II incidents were reported to the LME responsible for the catchment area were services are provided within 72 hours of learning of the incident. The findings are: Review on 5-27-22 of Level I incident report dated 4-5-22 revealed: -"The following information was gathered the vice president of residential services as well as the youth himself: -Sometime between 3/2-3/7- Conversation with staff [Staff #1] about being fat. This led to staff pulling up her shirt to show her stomach and also pulled her waistband to her pants. This completely shocked [Former Client #1 (FC#1)] and he was a bit confused about what happened. -[FC#1] asked another resident (Former Client #4) if he saw what happened and he stated that he did see the staff flashing [FC#1]. - As reported from the VP (Vice President) of Residential Operations on 4/4/22, this matter has been addressed. Residential called DSS	V 367		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRIST CHURCH COTTAGE THOMPSON CHILD & FA	6722 ST PETERS LANE MATTHEWS, NC 28105

(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 367	Continued From page 12 (Department of Social Services) to make a report of the allegation, created an incident report, completed an IRIS (Incident Response Improvement System), separated the accused staff member from [FC#1] and addressed this issue with all staff involved. - ...will complete an Incident report in Echo to document this allegation and document Residential ' s report to the state-level IRIS and the DSS report regarding the allegation." Interview on 6-9-22 with the Quality Improvement Specialist revealed: -She thought that an IRIS report had been done. Interview on 6-9-22 with the Supervisor revealed: -The former Vice President of Residential Services had told her that he would handle the situation and put the report in IRIS. Interview on 6-9-22 with IRIS customer service revealed: -There had been no report submitted for this incident and no report created but not submitted.	V 367		