STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601171	A. BUILDING: _____ B. WING _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORKE COTTAGE	6750 SAINT PETERS LANE, SUITE 100 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 000	INITIAL COMMENTS An annual and complaint survey was competed on 6-23-22. The complaint was substantiated (#NC00189074). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G 1900 Psychiatric Residential Treatment Facility for Children and Adolescents. This facility is licensed for six and currently has a census of five. The survey sample consisted of three current clients.	V 000		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based	V 109		

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V 109	Continued From page 1 employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record reviews and interviews, the Program Supervisor (Program Supervisor #1) failed to demonstrate competency. The findings are: Review on 5-31-22 of Program Supervisor #1's personnel record revealed: -Hire date 3-21-22. -Trainings include; First aid and Cardiopulmonary Resuscitation 4-11-22, TCI (Therapeutic Crisis Intervention) 4-8-22, and Orientation 3-21-22. Review on 6-1-22 of Supervisors training completed on 5-2-22 revealed: -All supervisors had been trained on incident reporting and policy updates. Review on 5-31-22 of Internal investigation dated 5-13-22 completed by the Quality Improvement Specialist revealed:	V 109		

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V 109	Continued From page 2 -"Upon speaking with staff following this incident it was determined that the client was out of sight. There were inconsistent reports on what had occurred. A kitchen knife was retrieved...and given to supervisors. No injuries or threatening behaviors had occurred as a result of the client having the knife. It is recommended that supervisors follow the incident reporting procedure and protocols to prevent future occurrences." -"Operations staff are not consistent in their report of this incident on determining if client was out of line of sight, how long he was gone, where he obtained the knife, and why he was not followed." -"No incident report was completed for this incident and guardian was notified by client during CFT (Child and Family Team) meeting." Review on 6-7-22 of AWOL (absent without leave) Procedures revealed: -"staff will maintain unbroken visual contact of the client to the greatest extent possible. Line of sight supervision is practiced with all clients; however, if the staff losses line of sight supervision during a runway attempt the following protocol will come into effect. Staff to client ratio during a runaway attempt and/or a successful AWOL must always be maintained. Staff should call for backup via walkie if additional staff is needed to maintain ratio during an AWOL attempt. If a client(s) breaks the line-of-sight supervision, the following procedures shall be followed: 1. Staff will immediately attempt to locate the client(s) if on-campus. If the client has walked off campus (leaving passed the gate) proceed to instruction 3. 2. On the residential treatment campus, staff should notify the other cottages and the	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 109	Continued From page 3	V 109		

administration building, to be on the lookout for the client(s).
- The staff of other programs should check the buildings to make sure that all the doors and windows are secure, and that the client(s) are not in the facility.
3. The Administrator on Call should be notified immediately (please refer to Administrator on Call calendar that is sent out monthly).
4. If a client is not located or if a client has left the campus:
a. the police will be notified, and a runaway report will be filed.
b. the guardian or parent and case manager will be notified.
5. If a client is not located within 3 hours the Residential Director, Clinical Supervisor, Vice President of Residential Services, and Chief Program Officer must be notified.
6. When the client(s) are located, all those notified of the runaway should be notified of the return of
the client(s).
7. A Life Space Interview will be conducted, and an alternate plan of behavior should be discussed.
8. A serious incident report should be submitted to the Program Director and the Performance & Quality Improvement department via the IRIS (Incident Response Improvement System) email same day as incident. PQI (Performance & Quality Improvement) staff will complete a Serious Occurrence report to Disability Rights by next business day.
9. For PRTF (Psychiatric Residential Treatment Facility) and Short Term Residential, an IRIS report should be submitted within 72 hours of the incident..."

Interview on 5-23-22 with Client #2 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601171	A. BUILDING: _____ B. WING _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 109	Continued From page 4 -"Yes did get off campus (referring to the 4-28 -22 incident). Staff was right behind me most of the time. I got maybe 20 minutes away. I out ran them for a little bit then I saw them and I started running. The van came to get me." -He did not know how long he was gone. -He had gone AWOL once before but had not left campus and came right back. Interview on 5-23-22 with Staff #1 revealed: -Last month Client #2 got off campus for an hour and came back with a bike and a knife. -"I don't think the police were called. I thought if a child is gone for more than 10 minutes out of line of site the police were called." -He was surprised that the police had not been called. Interview on 5-23-22 with Staff #2 revealed: -Client #2 had been getting on the van to go to school when he went AWOL. -Program Supervisor #1 told her that he would handle it and for her to go on to school with the rest of the clients. -She saw Program Supervisor #1 following Client #2. -Program Supervisor #1 "said he was going to call the police, but he was in line of site." Interview on 5-23-22 with Program Supervisor #1 revealed: -He had been chasing Client #2 and Client #2 had not gotten off campus. -He didn't know anything about the incident report. -They had been told a client was AWOL if they were off campus 3 hours and out of sight. Interview on 6-23-22 with the Quality Improvement Specialist revealed:	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601171	A. BUILDING: _____ B. WING _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 109	Continued From page 5 -They did an investigation of the incident. -They could never conclusively prove that Client #2 got off campus, but he was out of line of site. -Incident reports should have been done. -All supervisors were trained in incident reporting after this incident.	V 109		
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 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.	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601171	A. BUILDING: _____ B. WING _____	06/23/2022

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V 366	Continued From page 6 (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 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	V 366		

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	MHL0601171	A. BUILDING: _____ B. WING _____	06/23/2022

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V 366	Continued From page 7 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. This Rule is not met as evidenced by: Based on records review and interviews the facility failed to maintain documentation documentation of incidents. The findings are: Review on 5-31-22 of Client #2's record revealed: -Admitted 10-21-21. -11 years old.	V 366		

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	MHL0601171	A. BUILDING: _____ B. WING _____	06/23/2022

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V 366	Continued From page 8 -Diagnoses include: Post Traumatic Stress Disorder, Attention Deficit/Hyperactivity Disorder, and Oppositional Defiant Disorder. -Person Centered Plan last updated 5-24-22; goals include, -will identify and verbalize triggers that contribute to AWOL behaviors evidence by expressing thoughts and feelings through appropriate verbalizations and healthy physical outlets 5 out of 7 days a week for 3, will demonstrate a marked improvement in impulse control as evidence by a significant reduction in aggressive, disruptive and negative attention-seeking behaviors 3 out of 5 days a week. Review on 5-31-22 of Internal investigation dated 5-13-22 completed by the Quality Improvement Specialist revealed: -"Upon speaking with staff following this incident it was determined that the client was out of sight. There were inconsistent reports on what had occurred. A kitchen knife was retrieved...and given to supervisors. No injuries or threatening behaviors had occurred as a result of the client having the knife. It is recommended that supervisors follow the incident reporting procedure and protocols to prevent future occurrences." -"Operations staff are not consistent in their report of this incident on determining if client was out of line of sight, how long he was gone, where he obtained the knife, and why he was not followed." -"No incident report was completed for this incident and guardian was notified by client during CFT (Child and Family Team) meeting." Review on 6-1-22 of Supervisors training completed on 5-2-22 revealed: -All supervisors had been trained on incident	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601171	A. BUILDING: _____ B. WING _____	06/23/2022

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V 366	Continued From page 9	V 366		

reporting and policy updates.

Review on 6-1-22 of email sent to the Quality Improvement Specialist from Client #2's therapist dated 5-1-22 revealed:

-"I'm not sure if you were made aware that he (Client #2) went AWOL (absent without leave) while transitioning to school today. I initially found out about the incident from the staff at the school when I took one of the girls from [sister cottage] to school after our session this afternoon...
-... I was not sure if you were made aware of this incident. I have not seen an incident report on our end so I don't believe that the guardian has been contacted, but if he was able to speak with her, she may have been made aware by now."

Interview on 5-23-22 with Client #2 revealed:

-"Yes, I did get off campus (referring to the 4-28-22 incident). Staff was right behind me most of the time. I got maybe 20 minutes away. I out ran them for a little bit then I saw them and I started running. The van came to get me."
-He did not know how long he was gone.
-He had gone AWOL once before but had not left campus and came right back.

Interview on 5-23-22 with Staff #1 revealed:

-Client #2 had gone AWOL before.
-He has heard that Client #2 has gotten off campus twice.

Interview on 5-23-22 with Program Supervisor #1 revealed:

-He had been chasing Client #2 and Client #2 had not gotten off campus.
-He didn't know anything about the incident report.

Interview on 6-23-22 with the Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601171	A. BUILDING: _____ B. WING _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 366	Continued From page 10 Improvement Specialist revealed: -They did an investigation of the incident. -They could never conclusively prove that Client #2 got off campus, but he was out of line of site. -Incident reports should have been done. -All supervisors were trained in incident reporting after this incident.	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	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601171	A. BUILDING: _____ B. WING _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORKE COTTAGE	6750 SAINT PETERS LANE, SUITE 100 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 11	V 367		

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 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

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	MHL0601171	A. BUILDING: _____ B. WING _____	06/23/2022

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V 367	Continued From page 12 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 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 review and interview the facility failed to report all level II incidents reports to the LME catchment area were services are provided within 72 hours of learning of the incident. The findings are: Review on 5-31-22 of Client #2's record revealed: -Admitted 10-21-21. -11 years old. -Diagnoses include: Post Traumatic Stress Disorder, Attention Deficit/Hyperactivity Disorder, and Oppositional Defiant Disorder. -Person Centered Plan last updated 5-24-22; goals include, -will identify and verbalize triggers that contribute to AWOL behaviors evidence by expressing thoughts and feelings through appropriate verbalizations and healthy physical outlets 5 out of 7 days a week for 3, will demonstrate a marked improvement in impulse	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601171	A. BUILDING: _____ B. WING _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 367	Continued From page 13	V 367		

control as evidence by a significant reduction in aggressive, disruptive and negative attention-seeking behaviors 3 out of 5 days a week.

Review on 6-1-22 of email sent to the Quality Improvement Specialist from Client #2's therapist dated 5-1-22 revealed:

-"I'm not sure if you were made aware that he (Client #2) went AWOL (absent without leave) while transitioning to school today. I initially found out about the incident from the staff at the school when I took one of the girls from [sister cottage] to school after our session this afternoon. They informed me that the client that he was completely off campus and that the staff that was working 1st shift in Yorke today did not make any attempts to go after him once he took off. They stated that quite some time had passed (about 15 -20 minutes) before [Program Supervisor #1] was contacted and that none of the staff members tried to contact the police despite the staff at the school suggesting that they do so since he ran off campus and out of their sight. Apparently, he came back to campus on a bike and with a "kitchen knife" in his possession which [School personnel], school personnel, was able to convince him to turn over to her. He reported that he found the knife in the woods.

-I spoke with the nurse to see if she had any additional information once I returned to Upper. She was told that it was a line-of-sight AWOL yet when I met with him this afternoon and in our session, he confirmed that he was off campus and no one tried to get him. His story was pretty similar to that of the staff at the school. He admitted to having the bike and knife yet would not say where they came from. I know that the kids typically will say things, but I don't believe he would lie about this incident or exaggerate the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601171	A. BUILDING: _____ B. WING _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 367	Continued From page 14 story. He did mention contacting his legal guardian as well, so I wanted to make sure that you were kept in the loop since I was not sure if you were made aware of this incident. I have not seen an incident report on our end so I don't believe that the guardian has been contacted, but if he was able to speak with her, she may have been made aware by now." Review on 6-7-22 of AWOL Procedures revealed: -"staff will maintain unbroken visual contact of the client to the greatest extent possible. Line of sight supervision is practiced with all clients; however, if the staff losses line of sight supervision during a runway attempt the following protocol will come into effect. Staff to client ratio during a runaway attempt and/or a successful AWOL must always be maintained. Staff should call for backup via walkie if additional staff is needed to maintain ratio during an AWOL attempt. If a client(s) breaks the line-of-sight supervision, the following procedures shall be followed: 1. Staff will immediately attempt to locate the client(s) if on-campus. If the client has walked off campus (leaving passed the gate) proceed to instruction 3. 2. On the residential treatment campus, staff should notify the other cottages and the administration building, to be on the lookout for the client(s). - The staff of other programs should check the buildings to make sure that all the doors and windows are secure, and that the client(s) are not in the facility. 3. The Administrator on Call should be notified immediately (please refer to Administrator on Call calendar that is sent out monthly). 4. If a client is not located or if a client has left the campus:	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601171	A. BUILDING: _____ B. WING _____	06/23/2022

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V 367	Continued From page 15 a. the police will be notified, and a runaway report will be filed. b. the guardian or parent and case manager will be notified. 5. If a client is not located within 3 hours the Residential Director, Clinical Supervisor, Vice President of Residential Services, and Chief Program Officer must be notified. 6. When the client(s) are located, all those notified of the runaway should be notified of the return of the client(s). 7. A Life Space Interview will be conducted, and an alternate plan of behavior should be discussed. 8. A serious incident report should be submitted to the Program Director and the Performance & Quality Improvement department via the IRIS (Incident Response Improvement System) email same day as incident. PQI (Performance & Quality Improvement) staff will complete a Serious Occurrence report to Disability Rights by next business day. 9. For PRTF (Psychiatric Residential Treatment Facility) and Short Term Residential, an IRIS report should be submitted within 72 hours of the incident..." Review on 5-31-22 of Internal investigation dated 5-13-22 completed by the Quality Improvement Specialist revealed: -"Upon speaking with staff following this incident it was determined that the client was out of sight. There were inconsistent reports on what had occurred. A kitchen knife was retrieved...and given to supervisors. No injuries or threatening behaviors had occurred as a result of the client having the knife. It is recommended that supervisors follow the incident reporting procedure and protocols to prevent future	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601171	A. BUILDING: _____ B. WING _____	06/23/2022

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V 367	Continued From page 16	V 367		

occurrences."

-"Operations staff are not consistent in their report of this incident on determining if client was out of line of sight, how long he was gone, where he obtained the knife, and why he was not followed."

-"No incident report was completed for this incident and guardian was notified by client during CFT (Child and Family Team) meeting."

Interview on 5-23-22 with Client #2 revealed:

-"Yes did get off campus (referring to the 4-28 -22 incident). Staff was right behind me most of the time. I got maybe 20 minutes away. I out ran them for a little bit then I saw them and I started running. The van came to get me."

-He did not know how long he was gone.

-He had gone AWOL once before but had not left campus and came right back.

Interview on 5-23-22 with Staff #1 revealed:

-He had heard that Client #2 had gotten off campus twice during AWOL's.

-Last month Client #2 got off campus for an hour and came back with a bike and a knife.

-"I don't think the police were called. I thought if a child is gone for more than 10 minutes out of line of site the police were called."

-He was surprised that the police had not been called.

Interview on 5-23-22 with Staff #2 revealed:

-Client #2 had been getting on the van to go to school when he went AWOL.

-Program Supervisor #1 told her that he would handle it and for her to go on to school with the rest of the clients.

-She saw Program Supervisor #1 following Client #2.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 367	Continued From page 17 -Program Supervisor #1 "said he was going to call the police, but he was in line of site." -Staff #2 saw Client #2 on a bike when they had been on their way to recreation and also when they had been in school. Interview on 5-23-22 with Program Supervisor #1 revealed: -He had been chasing Client #2 and Client #2 had not gotten off campus. -He didn't know anything about the incident report. -They had been told a client was AWOL if they were off campus 3 hours and out of sight. Interview on 6-23-22 with the Quality Improvement Specialist revealed: -They did an investigation of the incident. -They could never conclusively prove that Client #2 got off campus, but he was out of line of site. -Incident reports should have been done. -All supervisors were trained in incident reporting after this incident.	V 367		
V 517	27E .0104(c-d) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (c) Restrictive interventions shall not be employed as a means of coercion, punishment or retaliation by staff or for the convenience of staff or due to inadequacy of staffing. Restrictive interventions shall not be used in a manner that causes harm or abuse. (d) In accordance with Rule .0101 of Subchapter 27D, the governing body shall have policy that	V 517		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 517	Continued From page 18 delineates the permissible use of restrictive interventions within a facility. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure restrictive interventions were not employed as a means of punishment, retaliation by staff, or a manner that causes harm or abuse affecting one of four clients (Client #1). The findings are: Review on 5-25-22 of Client #1's record revealed: -Admitted 11-16-21. -11 years old. -Diagnoses include: Conduct Disorder, Attention Deficit/Hyperactivity Disorder, and Bipolar Disorder. -Consent for therapeutic holds signed by Client #1's guardian on 11-16-21. -Assessment Addendum dated 4-29-22 revealed: ..".has struggle managing his impulsive behaviors. He engages in acts of physical or verbal aggression almost daily. These aggressive acts can occur without a trigger or due to him reacting disproportionately to a situation..." -Person Centered Plan last updated 4-6-22 revealed: refuses therapy, struggles to implement coping skills...goals include; improve academic performance, build the skills necessary to develop healthy communication skills and mechanisms for handling frustrations and anger with his siblings, will refrain from physical and verbal aggression when he is angry or frustrated. Review on 5-31-22 of Program Supervisor #1's personnel record revealed: -Hire date 3-21-22. -Trainings include; First aid and	V 517		

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V 517	Continued From page 19 Cardiopulmonary Resuscitation 4-11-22, and TCI (Therapeutic Crisis Intervention) 4-8-22. Review on 5-23-22 of incident report dated 4-28-22 completed by the Program Supervisor #1 revealed: -"Client (Client #1) was participating in recreational therapy. [Client #1] was beginning to deregulated emotionally. Due to his anger he left the recreation room after staff asked him to remain in the room. He was outside the recreation room and reentered toward a bookcase where another client was using a CD (compact disc) player and microphone by themselves. [Client #1] and the other client began to display verbal aggression towards one another. Another staff member assisted with removing the other client from the situation to assist with de-escalation. [Client #1] constantly was pursuing after the other client. Items were being thrown, and [Client #1] continued to pursue the other client. The two clients then began to hit and kick at one another. Staff them utilized a TCI maneuver to to remove [Client #1], to prevent any more violent exchanges. [Client #1] was relocated outside of the recreation room, where [Client #1] proceeded to be verbally aggressive towards staff (Program Supervisor #1). [Client #1] then proceeded to curse at staff and swung his fist at staff. Staff (Program Supervisor#1) then proceeded to place [Client #1] into a small child restraint." -Nursing assessment for incident report; "Per staff report, client (Client #1) appeared to be wheezing immediately after RI (Restrictive Intervention). When nurse was present his breathing was normal. Vitals obtained; resp (respiration) 13, oxygen saturation 98% pulse, 70." -"Client (Client #1) calm and c/o (complained	V 517		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 517	Continued From page 20	V 517		

of) feeling weak and tired. He is alert and oriented to all spheres."

Review on 5-23-22 of email dated 5-4-22 from the Quality Improvement Specialist to the Program Supervisor #2 revealed:

-"Yesterday I was made aware of a client concern regarding the use of an improper restraint on 4/28 involving client [Client #1] and [Program Supervisor#1]. It was reported that the client was restrained due to behaviors exhibited during rec (recreation) therapy. During the restraint it is was described that staff had client in a small child and leaned forward to prevent the client from head butting. The restraint was not witnessed by nursing; however, it is reported that nursing was notified following the incident due to the client wheezing and seeming to be disoriented following the intervention..."

Review on 5-25-22 of Supervision Documentation dated 5-18-22 for Program Supervisor#1 and signed by his Director revealed:

-"Director met with [Program Supervisor#1], Program Supervisor and discussed feedback related to recent therapeutic intervention that occurred with [Client #1] as there were reported concerns related to the clients (Client #1) level of agitation within the hold and his development of symptoms that mirrored hyperventilation. For coaching support purposes, Director emphasized the importance of always checking to ensure TCI technique is maintained in Small Child Restraint as it relates to the locking of elbows. Director did video reviews of two additional holds that [Program Supervisor#1] participated in and no concerns were noted in regard to TCI technique and positioning."

Interview on 5-23-22 with Client #1 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601171	A. BUILDING: _____ B. WING _____	06/23/2022

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V 517	Continued From page 21	V 517		

-"He (Program Supervisor#1) has restrained me. He hurt me so bad I couldn't move. My arms were crossed really tight and I would be on my knees and it would hurt. My arms were numb. But he is ok except for that. No nurse was watching, I don't remember who came in."

Interview on 5-23-22 with Program Supervisor #1 revealed:

-The protocol for restraints should be that staff contacts the nurse before the restraint and the nurse monitors the restraint. When the child is calmer, they release the client and the nurse assesses them.

-The nurse had not been contacted when he restrained Client #1 one day, he could not remember the exact date.

-Client #1 was being disruptive and trying to get in a confrontation with another client when they were in the recreation room.

-He took Client #1 outside to separate them.

-"He (Client #1) cursed, and swung at me, I put him in small child restraint. The staff did not know to call the nurse."

-The Recreational Therapist worked in the recreation room and watching the restraint.

-The Recreational Therapist attempted to call the nurse from Client #1's cottage, then called the nurse from a nearby cottage

-During the restraint Client #1 was "being unruly, yelling 'I can't breathe.'"

-He (Program Supervisor #1) stopped the restraint, he (Client #1) was "very exhausted."

-The nurse from the nearby cottage came and then the nurse from Client #1's cottage came.

Interview on 6-8-22 with the Recreation Therapist revealed:

-She remembers that Client #1 was being

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601171	A. BUILDING: _____ B. WING _____	06/23/2022

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V 517	Continued From page 22	V 517		

aggressive with staff.

-"He (Client #1) punched a staff, that is when [Program Supervisor #1] restrained him."

-"They (Program Supervisor #1) did a cross arm restraint and it lasted about ten minutes."

-She was watching the door to the recreation room to watch the other clients and watching the restraint.

-"[Client #1] was fighting. I don't remember anything happening we weren't taught to do."

-A nurse had not been called before the restraint was initiated.

-She was told to call the nurse, but couldn't get in contact with the nurse from Client #1's cottage so she called the nurse from a nearby cottage.

-She saw Client #1 panting and breathing faster than normal.

-When she saw him after the restraint he was sitting on the ground next to Supervisor #1, who was giving him some water before the nurse got there.

-The Recreation Therapist thought Client #1 might have had a panic or anxiety attack.

- Program Supervisor #1 never had his arms or hands around Client #1's neck. "I can say that for sure."

-This was the only restraint she can remember that a nurse wasn't present.

Interview on 5-23-22 with staff who wished to remain anonymous revealed:

-She was called by the nurse at a nearby cottage and was told there was a restraint and they needed her to come.

-She had no knowledge of this before receiving that call, so she got into her car and drove over to the recreation building.

-She saw Client #1 on the ground with his head in the Program Supervisor #1's lap.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601171	A. BUILDING: _____ B. WING _____	06/23/2022

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V 517	Continued From page 23 -Client #1 was limp with his eyes closed. -She asked Client #1 questions and he could answer her after a few seconds. -She took his vitals and they were normal. -They got him off the ground and helped him to a chair. -Client #1 said he couldn't walk and so they got him a ride to the cafeteria to eat lunch and he was fine the rest of the day. -Client #1 does not have asthma or seizures. The other staff said he was just so "wild" he wore himself out. -She had heard from another staff that that Client #1 was trying to head butt Program Supervisor #1 so the Program Supervisor #1 bent over and it "pushed the air out" of Client #1 and Client #1 started coughing. -She had also heard from another staff that Program Supervisor #1 did not ask the nurse to be called until he started gasping. -She had not wanted to identify the staff that told her this. -By the time she got to the recreation room, Client #1 was not being restrained anymore. Interview on 6-1-22 with the Maintenance Man revealed: -He was outside of the Recreation room when he heard a "commotion." -He saw Client #1 and Program Supervisor #1 on the ground. -Program Supervisor #1 had Client #1 in a restraint and Client #1 was "yelling and screaming." -Client #1 would take his head and throw it back into Program Supervisor #1's chest. -Program Supervisor #1 was sitting with his arms crossed over Client #1's chest. -At no time did he see Program Supervisor #1's hands or arms around Client #1's neck.	V 517		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601171	A. BUILDING: _____ B. WING _____	06/23/2022

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V 517	Continued From page 24 -Client #1 started wheezing because he wasn't calming down and looked like he was having trouble breathing. -Program Supervisor #1 let him go and tried to make him comfortable. . -"...Almost as soon as I got there, [Program Supervisor #1] told me to call the nurse. This was before the kid (Client #1) had any trouble." -"When the kid was restrained there was no nurse." -A nurse was there by the time Client #1 was having trouble breathing. -He gave him a ride to the cafeteria after the nurses had done their assessment and Client #1 seemed calm. Review of the Plan of Protection dated 6-23-22 and signed by the Chief Performance and Quality Officer revealed: What immediate action will the facility take to ensure the safety of the consumers in your care? "Director of Nursing will send an email communication on 6-23-22 to all nursing and Yorke Cottage RCS (Residential Counseling Specialists) staff reiterating the procedure for restraints including calling the nurse prior to the restraint and the nurse observing the restraint to assess for safety. Program Supervisor (Program Supervisor #2) will send same communication and protocols to residential staff on Microsoft teams on 6-23-22. Program Supervisor (Program Supervisor #2) is sending text message of protocol to all RCS staff in Yorke to ensure communication is received prior to starting shift. At the next staff meeting for nursing and for Yorke cottage staff, leaders will cover the restraint	V 517		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601171	A. BUILDING: _____ B. WING _____	06/23/2022

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V 517	Continued From page 25	V 517		

protocols to include calling the nurse to receive doctors orders, nursing observation, monitoring and follow up. This will provide opportunity for staff to ask any questions regarding the procedure. The nest staff meeting for both residential and nursing will occur July 12, 2022."

Describe your plan to make sure the above happens.

"Chief Procedure & Quality Officer will be copied on email communication to staff on 6-23-22 to ensure that communication goes out and a read receipt will be requested in the email.
PQI (Performance Quality Improvement) will follow up with Director of Nursing and Yorke leader to ensure protocols were discussed in the July Staff Meeting."

Client #1 had diagnoses of Conduct Disorder, Attention Deficit/Hyperactivity Disorder, and Bipolar Disorder. He had episodes of physical and verbal aggression daily. Program Supervisor #1 put Client #1 into a physical restraint without letting a nurse know so that the restraint could be monitored for safety. Client #1 began to wheeze and breathe abnormally fast according to staff that was observing. Client #1 said he was weak and confused. Nurses did check vital signs when they arrived, but the restraint was over at that time. Due to the restraint not having a nurse monitor for safety, and the client having a possible reaction to the restraint, this put Client #1 at substantial risk for serious harm. This deficiency constitutes a Type A2 rule violation for substantial risk of serious harm and must be corrected within 23 days. No administration penalty has been assessed. If the violation is not corrected within 23 days, an additional penalty of

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V 517	Continued From page 26 500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 517		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: The facility failed to be maintained in a safe, clean, attractive manner and free from offensive odor. The findings are: Observation on 6-1-22 at approximately 4:00 pm revealed: -Bedroom #2 had no light in the bathroom. -Bedroom #4 had approximately 3 inches of standing water in the bathtub. The bathroom smelled strongly of urine. -Bedroom #5 had a light that was blinking and then went out in the bathroom, feces on the rim and sides of the toilet, foul odor in the bathroom. Interview on 6-1-22 with Client #1 revealed: -He lived in Bedroom #2. -He would wet his washcloth and step into the rest of the bathroom so he could see when he showered. -He couldn't remember if he had told anyone about the light being off.	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601171	A. BUILDING: _____ B. WING _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORKE COTTAGE	6750 SAINT PETERS LANE, SUITE 100 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 736	Continued From page 27 Interview on 6-3-22 with the Program Supervisor revealed: -Client #3 had admitted to urinating on the floor. -The staff does do walk through's of the cottage. "We try to do them three times a week but everyday staff are directed to clean their rooms. Staff knows rooms need to be checked." -She had put in a ticket for the issues to be corrected.	V 736		