STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080-216	A. BUILDING: _____ B. WING _____	R 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TMR RESIDENTIAL	1335 WEST RIDGE ROAD SALISBURY, NC 28147

(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, complaint, and follow up survey was completed on July 7, 2022. The complaint was unsubstantiated (Intake #NC00189353). Deficiencies were cited. The facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 4 and currently has a census of 4. The survey sample consisted of audits of 2 current clients and 1 former client. A sister facility is identified in this report. The sister facility is identified as Sister Facility A. Sister Facility A is located on property adjacent to the facility.	V 000		
V 117	27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name;	V 117		

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V 117	Continued From page 1 (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner. This Rule is not met as evidenced by: Based on interview, record review, and observation, the facility failed to ensure medications contained packaging labels with medication dispense date and clear directions for administration affecting 1 of 2 audited clients (Client #2). The findings are: Review on 6/23/22 and 7/5/22 of Client #2's record revealed: -Admitted 6/1/22; -Diagnosed with Attention Deficit Hyperactivity Disorder, Unspecified Trauma and Stressor Related Disorder; -16 years old; -Physician's order dated 5/31/22 for Topiramate (mood) 50mg (milligrams) 1 tab (tablet) twice daily. Observation on 6/23/22 at approximately 9:10am of Client #2's medications revealed: -Topiramate 50mg with pharmacy label partially ripped off resulting in no dispense date and no directions for administration.	V 117		

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V 117	Continued From page 2 Interview on 6/23/22 with the Qualified Professional #1 revealed: -Was not aware that the pharmacy label was partially ripped off resulting in no dispense date and no directions for administration for Client #2's Topiramate; -Will ensure all pharmacy labels remain intact in the future. This deficiency is cross referenced to 10A NCAC 27G .0209 Medication Requirements (V118) for a Type A1 rule violation and must be corrected within 23 days.	V 117		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug;	V 118		

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V 118	Continued From page 3 (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on interview, record review, and observation, the facility failed to ensure medications were administered on the written order of a person authorized by law to prescribe medications and failed to ensure MARs were kept current affecting 2 of 2 audited clients (Clients #1, and #2). The findings are: CROSS REFERENCE: 10A NCAC 27G .0209 Medication Requirements (V117) Based on interview, record review, and observation, the facility failed to ensure medications contained packaging labels with medication dispense date and clear directions for administration affecting 1 of 2 audited clients (Client #2). CROSS REFERENCE: 10A NCAC 27G .0209 Medication Requirements (V123) Based on interview, record review, and observation, the facility failed to ensure all medication administration errors were reported to a pharmacist or physician affecting 2 of 2 audited clients (Clients #1 and #2).	V 118		

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V 118	Continued From page 4 Review on 6/23/22 and 7/5/22 of Client #1's record revealed: -History of impulsive and emotional behaviors leading to verbal and physical aggression, exposure to domestic violence and sexual abuse, suicidal ideation, and AWOL (absent without leave); -Physician's order for: -Escitalopram (antidepressant) 10mg (milligram) 1 tab (tablet) daily dated 2/24/22 with discontinue order dated 6/8/22; -Melatonin (sleep) 3mg 1 tab at bedtime dated 6/8/22; -Latuda (antipsychotic) 20mg 1 tab daily dated 6/8/22; -No physician's orders for: -Multivitamin (supplement); -Melatonin 5mg 2 tabs at bedtime; -May, 2022 MAR (5/27-5/31 administration dates) revealed administration of: -Melatonin 5mg 2 tabs at bedtime; -No documentation of Multivitamin; -June, 2022 MAR (6/1-6/23 administration dates) revealed administration of: -Escitalopram 10mg 1 tab daily administered despite the discontinue order on 6/8/22; -Melatonin 5mg 2 tabs at bedtime; -No documentation of administration of Multivitamin; -No documentation of administration of Latuda 20mg 1 tab daily; Observation on 6/23/22 at approximately 9am of Client #1's medications revealed: -Escitalopram 10mg 1 tab daily dispensed 3/1/22; -Multivitamin dispensed 3/1/22; -No Melatonin. Interview on 6/23/22 with Client #1 revealed:	V 118		

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V 118	Continued From page 5 -Was supposed to be receiving Latuda but had not received it in the past two weeks since it was first ordered; -Received multivitamin daily. Interview on 6/23/22 and 7/6/22 with the Associate Professional #1/House Manager (AP#1/HM) revealed: -It was an error when she initialed Client #1's MAR indicating administration of Melatonin on 6/22/22 as there was no Melatonin in the facility. Review on 6/23/22 and 7/5/22 of Client #2's record revealed: -History of poor anger management skills leading to verbal and physical aggression, exposure to domestic violence, recent inpatient hospitalization discharge (6/1/22) as a result of physical aggression and assault; -Physician's order dated 5/31/22 for Atomoxetine (antipsychotic) 100mg 1 cap (caplet) daily, Oxcarbazepine (mood) 600mg 1 tab twice daily, Aripiprazole (attention) 15mg 1 tab daily, Topiramate (mood) 50mg 1 cap twice daily, Clonidine (attention) 0.2mg 1 tab daily, and Fluticasone Propionate (allergies) 44 mcg (micrograms) 2 puffs per nostril twice daily; -June, 2022 MAR revealed: -Missed doses of Fluticasone Propionate on 6/1/22, 6/2/22, and 6/17/22 at 7am and no doses administered at 7pm for 6/1/22-6/23/22; -Oxcarbazepine 600mg documented as administered once daily at 7am; -No documentation of administration of Atomoxetine 100mg, Oxcarbazepine 600mg, Aripiprazole 15mg, Topiramate 50mg on 6/1/22 and 6/2/22 and no documentation of administration of Clonidine 0.2mg on 6/1/22; Observation on 6/23/22 at approximately 9:10am	V 118		

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V 118	Continued From page 6 of Client #2's medications revealed: -Atomoxetine 100mg, Oxcarbazepine 600mg, Aripiprazole 15mg, Clonidine 0.2mg dispensed on 5/31/22; -Topiramate 50mg with a partially ripped label with no dispense date and no administration directions; -No Fluticasone Propionate. Interview on 6/23/22 with Client #2 revealed: -Could not identify any medications she received; -Was dependent on staff for administration of medications. Interview on 6/23/22 and 7/6/22 with the QP#1 revealed: -Did not identify that there was no physician's order for Client #1's multivitamin; -Could not explain why the MARs were not kept current for Client #1 and Client #2; -Could not explain the discrepancies in Client #1's Melatonin dose; -Could not explain why Client #1 was still receiving Escitalopram after a discontinue order was written; -Could not explain why Client #1 had not been started on Latuda despite the order being written over two weeks prior; -Could not explain the discrepancies with Client #2's Fluticasone Propionate and why it was being documented as administered despite not being in the facility and Client #2 denying she received nasal spray; -Will make sure all MARs are kept current and all medications are administered as ordered. Interview on 7/7/22 with the Qualified Professional #2/Licensee (QP#2/L) revealed: -Challenges with Client #1 and Client #2's MARs and medication administration arose because	V 118		

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V 118	Continued From page 7 both clients were recent admissions to the facility; -Will ensure all new medication orders are filled and the medications are present in the facility within 24 hours in the future; -Will ensure all medications are present in the facility, administered as ordered, and documented on the MARs in the future. Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician. Review on 7/7/22 of the Plan of Protection signed by the QP#2/Licensee dated 7/7/22 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? TGH Behavioral Health Services, Inc. (Licensee) will ensure medication requirements are followed per the rule 10A NCAC 27G .0209. Describe your plans to make sure the above happens. As of July 6, 2022 [Client #1]'s melatonin has been corrected from 5mg to 3mg. this has been reviewed by [Qualified Professional #2/Licensee] (QP#2/L) As of July 6, 2022 The agency will ensure the physicians medication orders and/or discontinue orders are received in hand and/or via fax directly to the agency to ensure the orders are delivered to the pharmacy and correctly entered onto the Mar's prior to staff leaving the physician's office'. This will be reviewed by [QP#2/L] As of July 7, 2022 if no medications can be delivered within 24 hours, TGH Behavioral Services Inc will be responsible for picking up medications from the pharmacy	V 118		

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V 118	Continued From page 8 As of July 7, 2022 if the medication that has been prescribed is not available, the pharmacy will provide a written document stating that the medication is not available, along when the medication will be available for pick up. As of July 7, 2022 A follow up call will be made by [QP#2/L] to the pharmacy to ensure that the prescriptions have been received from the physician As of July 7, 2022 No medications will be accepted for new residents unless it is sent to our pharmacy [Local pharmacy] where the medications will be properly filled and packed. This will be ensure by [QP#2/L] and Qualified Professional #1 (QP#1) As of July 7, 2022 a review of the MAR (medication administration record), prescriptions and medications for each resident will be conducted by [QP#2/L] to ensure accuracy As of July 7, 2022 the pharmacy [local pharmacy] will also provide a review of residents medications every two months PLEASE NOTE: During the site visit the pharmacist explained that there was communication error from the original medication order and the pharmacy attempted multiple times to gain clarity. The agency administered medications as written." Clients #1 and #2 were 15 and 16 years old, respectively. They were diagnosed with mental health needs including Attention Deficit Hyperactivity Disorder and Unspecified Trauma and Stressor Related Disorder. They were both	V 118		

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V 118	Continued From page 9	V 118		

prescribed medications to assist in controlling their physical and mental health needs. Client #1 had a history of impulsive and emotional behaviors leading to verbal and physical aggression, exposure to domestic violence and sexual abuse, suicidal ideation, and AWOL (absent without leave). Client #2 had a history of poor anger management skills leading to verbal and physical aggression, exposure to domestic violence, and recent inpatient hospitalization as a result of physical aggression and assault. Client #1's medications were not administered as ordered by her physician. She was administered Escitalopram despite it being discontinued, but was not administered Latuda despite it being ordered. This occurred for over two weeks without the facility identifying or rectifying the medication error. Additionally, Client #1 was administered an incorrect dose of Melatonin for over three weeks and was administered multivitamin daily despite not having a physician's order. Client #2 was ordered Fluticasone Propionate twice daily but there was none at the facility on 6/23/22 and Client #2 denied ever using a nasal spray while at the facility. Furthermore, Clients #1 and #2's medication administration records were not kept current. No contact was made to a physician or pharmacist when Client #1 missed one dose of Melatonin and Client #2 missed several doses of Fluticasone Propionate. Finally, Client #2's Topiramate had a partially ripped pharmacy packaging label making it impossible to determine the dispense date or the dispensing directions. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2,000.00 is imposed. If the violation is nor corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out

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V 118	Continued From page 10 of compliance beyond the 23rd day.	V 118		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. . This Rule is not met as evidenced by: Based on interview, record review, and observation, the facility failed to ensure all medication administration errors were reported to a pharmacist or physician affecting 2 of 2 audited clients (Clients #1 and #2). The findings are: Review on 6/23/22 and 7/5/22 of Client #1's record revealed: -Admitted 5/27/22; -Diagnosed with Attention Deficit Hyperactivity Disorder, Major Depressive Disorder, Unspecified Trauma and Stressor Related Disorder; -15 years old; -Physician's order dated 6/8/22 for Melatonin (sleep) 3mg (milligrams) 1 tab (tablet) at bedtime; -No documentation of contact to a physician or pharmacist regarding the missed dose of Melatonin.	V 123		

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V 123	Continued From page 11 Observation on 6/23/22 at approximately 9am of Client #1's medications revealed: -No Melatonin. Interview on 6/23/22 with Client #1 revealed: -Did not receive Melatonin on 6/22/22; -The last Melatonin was administered on the evening of 6/21/22; -Did not sleep well without her Melatonin because of her sexual abuse history resulting in bad memories and inability to sleep. Interview on 6/23/22 and 7/6/22 with the Associate Professional #1/House Manager (AP#1/HM) revealed: -Client #1 was not administered Melatonin on 6/22/22 because she had been administered the last dose on 6/21/22; -Client #1 needs more Melatonin; -The Qualified Professional #1 (QP#1) was responsible for ensuring medications were at the facility. Review on 6/23/22 and 7/5/22 of Client #2's record revealed: -Admitted 6/1/22; -Diagnosed with Attention Deficit Hyperactivity Disorder, Unspecified Trauma and Stressor Related Disorder; -16 years old; -Physician's order dated 5/31/22 for Fluticasone Propionate (allergies) 44 mcg (micrograms) 2 puffs per nostril twice daily; -June, 2022 Medication Administration Record (MAR) revealed missed doses of Fluticasone Propionate on 6/1/22, 6/2/22, and 6/17/22 at 7am and no doses administered at 7pm for 6/1/22-6/23/22; -There was no documentation of contact to a	V 123		

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V 123	Continued From page 12 physician or pharmacist regarding the missed doses of Fluticasone Propionate. Observation on 6/23/22 at approximately 9:10am of Client #2's medications revealed: -No Fluticasone Propionate. Interview on 6/23/22 with Client #2 revealed: -Never used nasal spray since admission to the facility. Interview on 6/23/22 and 7/6/22 with the QP #1 revealed: -All staff were responsible to ensure clients were administered the correct medication; -Did not contact a physician or pharmacist when Clients #1 and #2 missed doses of medications; -Will ensure all missed medication doses are discussed with a physician or pharmacist in the future. This deficiency is cross referenced to 10A NCAC 27G .0209 Medication Requirements (V118) for a Type A1 rule violation and must be corrected within 23 days.	V 123		
V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of	V 293		

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V 293	Continued From page 13 this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to a community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care.	V 293		

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	MHL080-216	A. BUILDING: _____ B. WING _____	R 07/07/2022

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TMR RESIDENTIAL	1335 WEST RIDGE ROAD SALISBURY, NC 28147

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V 293	Continued From page 14 This Rule is not met as evidenced by: Based on interview, record review, and observation, the facility failed to minimize the occurrence of behaviors related to functional deficits and provide active therapeutic treatment affecting 2 of 2 audited clients (Clients #1 and #2). The findings are: CROSS REFERENCE: 10A NCAC 27G .1704 Minimum Staffing Requirements (V296) Based on interview, record review, and observation, the facility failed to maintain a minimum staffing ratio of two staff for up to four adolescents. Review on 7/7/22 of the first Plan of Protection (POP) signed by the Qualified Professional #2/Licensee (QP#2/L) dated 7/7/22 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? TGH Behavioral Health Services, Inc. (Licensee) will ensure that minimum staffing requirements are met per the rule 10A NCAC 27G .1704. The Director will be onsite at 8am to provide additional coverage. The agency has hired 7 days on, 7 days off staff to ensure 24/7/365 coverage. Describe your plans to make sure the above happens. TGH Behavioral Services, Inc. will present an "Immediate Need" post on hiring platforms such as Indeed.com to hire qualified individuals to work with the population served [adolescent females with MH (mental health) diagnosis]. TGH Behavioral Health Services Inc has hired a 7 day on 7 days off staff member who has started	V 293		

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V 293	Continued From page 15 as of June 16, 2022 TGH Behavioral Health Services Inc has posted three separate job posting on Indeed as of July 7, 2022" Review on 7/7/22 of the second POP signed by the QP#2/L dated 7/7/22 revealed: The following information was changed from the first POP: "Describe your plans to make sure the above happen. As of July 7, 2022 all staff is required to be on time for their scheduled shift. As of July 7, 2022 no staff will leave until the incoming shift has arrived. This will ensure that the staffing requirements are met per the rule 10A NCAC 27G .1704 As of July 7, 2022 TGH Behavioral Health Services Inc is actively looking for staff to hire for a 7 day on and 7 day off shift, double shifts, starting on Sunday and ending on Sunday." Clients #1 and #2 were 15 and 16 years old, respectively. They were diagnosed with mental health needs including Attention Deficit Hyperactivity Disorder and Unspecified Trauma and Stressor Related Disorder. Client #1 had a history of impulsive and emotional behaviors leading to verbal and physical aggression, exposure to domestic violence and sexual abuse, suicidal ideation, and AWOL (absent without leave). Client #2 had a history of poor anger management skills leading to verbal and physical aggression, exposure to domestic violence, and recent inpatient hospitalization as a result of physical aggression and assault. The Associate Professional #1/House Manager (AP#2/HM) was	V 293		

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V 293	Continued From page 16 the only staff member at the facility with four clients on 6/23/22 when Client #2 engaged in a behavioral outburst. Client #2 required AP#1/HM's attention resulting in the other three clients being sent to their bedrooms. AP#1/HM called Staff #1 on the telephone and requested Staff #1 come to the facility to provide assistance and supervision during the behavioral outburst. Staff #1 was at Sister Facility A which was located on property adjacent to the facility. The facility's failure to maintain minimum staffing requirements was detrimental to the health, safety, and welfare of the clients. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety, and welfare of the clients. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 293		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or	V 296		

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V 296	Continued From page 17 adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on interview, record review, and observation, the facility failed to maintain a minimum staffing ratio of two staff for up to four adolescents. The findings are: Review on 6/23/22 and 7/5/22 of Client #1's record revealed:	V 296		

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V 296	Continued From page 18 -Admitted 5/27/22; -Diagnosed with Attention Deficit Hyperactivity Disorder, Major Depressive Disorder, Unspecified Trauma and Stressor Related Disorder; -15 years old; -History of impulsive and emotional behaviors leading to verbal and physical aggression, exposure to domestic violence and sexual abuse, suicidal ideation, and AWOL (absent without leave). Review on 6/23/22 and 7/5/22 of Client #2's record revealed: -Admitted 6/1/22; -Diagnosed with Attention Deficit Hyperactivity Disorder, Unspecified Trauma and Stressor Related Disorder; -16 years old; -History of poor anger management skills leading to verbal and physical aggression, exposure to domestic violence, recent inpatient hospitalization discharge (6/1/22) as a result of physical aggression and assault. Interviews on 6/23/22 with the Associate Professional #1/House Manager (AP#1/HM) and Staff #1 and observation on 6/23/22 at approximately 8:00am-9:00am revealed: -Division of Health Service Regulation (DHSR) staff was greeted at the facility front door by the AP#1/HM; -AP#1/HM revealed she needed to contact the Qualified Professional #2/Licensee (QP#2/L) prior to DHSR staff entry into the facility; -AP#1/HM made a phone call and returned into the facility; -Staff #1 walked across the yard from Sister Facility A while speaking on a cell phone; -DHSR staff called out to Staff #1 from the front door to advise Staff #1 of the purpose of the visit;	V 296		

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V 296	Continued From page 19 -Staff #1 acknowledged the reason for the visit and proceeded around the back of the facility and entered the facility; -Staff #1 appeared at the front door of the facility and revealed: "[AP#1/HM] is in here too. There are two of us here now;" -Staff #1 revealed she needed to wait prior to allowing DHSR staff entry to the facility and offered a chair on the front porch; -Staff #1 revealed she had been called to the facility when Client #2 began a behavioral outburst and needed to be calmed down; -AP#1/HM could be heard telling Client #2 to calm down several times; -AP#1/HM could be heard telling Client #2 she needed "to learn to keep your hands to yourself;" -AP#1/HM could be heard telling all clients to go to their bedrooms and stay in their bedrooms during the incident; -Staff #1 left the facility to return to Sister Facility A upon arrival of the Qualified Professional #1 (QP#1); -Staff #1 did not return back to the facility during the remainder of the DHSR staff visit. Interview on 6/23/22 with Client #1 revealed: -There were generally two staff per shift, but today there was only one staff (AP#1/HM) working in the morning. Interview on 6/23/22 with Client #2 revealed: -Was upset this morning which resulted in her threatening her roommate (Client #4); -Usually there were two staff working each shift; -Only one staff (AP#1/HM) worked the morning shift this morning; -AP#1/HM called Staff #1 to the facility; -Staff #1 was working at Sister Facility A. Interviews on 6/23/22 and 7/6/22 with AP#1/HM	V 296		

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V 296	Continued From page 20 revealed: -Staff #1 was at Sister Facility A when DHSR staff arrived at the facility on 6/23/22; -Client #2 was upset and threatened her roommate (Client #4); -Called Staff #1 to come to the facility to assist her; -Needed to calm Client #2 before she could allow entry of DHSR staff to the facility; -Two staff work per shift, but Staff #1 was busy taking the garbage out at Sister Facility A on the morning of 6/23/22 when DHSR staff arrived at the facility. Interviews on 6/23/22 and 7/6/22 with Staff #1 revealed: -Worked at both Sister Facility A and the facility; -Was at Sister Facility A when DHSR staff arrived at the facility on 6/23/22; -Left the facility on 6/23/22 to take the garbage out from Sister Facility A; -Returned to the facility on 6/23/22 when she received a telephone call from the AP#1/HM. Interview on 7/6/22 with the QP#1 revealed: -Staff #1 had been working at the facility on 6/23/22 during the morning hours but had left the facility for a short period of time to go to Sister Facility A to take the garbage out; -There were always two staff at the facility when clients were present. Interview on 7/7/22 with the QP#1 and the QP#2/L revealed: -There were always two staff at the facility when clients were present. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type B rule violation and must be corrected within 45 days.	V 296		

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V 364	G.S. 122C- 62 Additional Rights in 24 Hour Facilities § 122C-62. Additional Rights in 24-Hour Facilities. (a) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-61, each adult client who is receiving treatment or habilitation in a 24-hour facility keeps the right to: (1) Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary; (2) Contact and consult with, at his own expense and at no cost to the facility, legal counsel, private physicians, and private mental health, developmental disabilities, or substance abuse professionals of his choice; and (3) Contact and consult with a client advocate if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each adult client may exercise these rights at all reasonable times. (b) Except as provided in subsections (e) and (h) of this section, each adult client who is receiving treatment or habilitation in a 24-hour facility at all times keeps the right to: (1) Make and receive confidential telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over therapies; (3) Communicate and meet under appropriate supervision with individuals of his own choice upon the consent of the individuals; (4) Make visits outside the custody of the facility unless:	V 364		

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V 364	Continued From page 22 a. Commitment proceedings were initiated as the result of the client's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found not guilty by reason of insanity or incapable of proceeding; b. The client was voluntarily admitted or committed to the facility while under order of commitment to a correctional facility of the Division of Adult Correction of the Department of Public Safety; or c. The client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; A court order may expressly authorize visits otherwise prohibited by the existence of the conditions prescribed by this subdivision; (5) Be out of doors daily and have access to facilities and equipment for physical exercise several times a week; (6) Except as prohibited by law, keep and use personal clothing and possessions, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Keep and spend a reasonable sum of his own money; (9) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes; and (10) Have access to individual storage space for his private use. (c) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-57 and G.S. 122C-59 through G.S. 122C-61, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to have access to proper adult supervision and guidance. In recognition of the minor's status as a developing individual, the minor shall be provided	V 364		

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V 364	Continued From page 23 opportunities to enable him to mature physically, emotionally, intellectually, socially, and vocationally. In view of the physical, emotional, and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate structure, supervision and control consistent with the rights given to the minor pursuant to this Part. The facility shall also, where practical, make reasonable efforts to ensure that each minor client receives treatment apart and separate from adult clients unless the treatment needs of the minor client dictate otherwise. Each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to: (1) Communicate and consult with his parents or guardian or the agency or individual having legal custody of him; (2) Contact and consult with, at his own expense or that of his legally responsible person and at no cost to the facility, legal counsel, private physicians, private mental health, developmental disabilities, or substance abuse professionals, of his or his legally responsible person's choice; and (3) Contact and consult with a client advocate, if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each minor client may exercise these rights at all reasonable times. (d) Except as provided in subsections (e) and (h) of this section, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to: (1) Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Send and receive mail and have access to writing materials, postage, and staff assistance when necessary;	V 364		

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V 364	Continued From page 24 (3) Under appropriate supervision, receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over school or therapies; (4) Receive special education and vocational training in accordance with federal and State law; (5) Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with his needs; (6) Except as prohibited by law, keep and use personal clothing and possessions under appropriate supervision, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Have access to individual storage space for the safekeeping of personal belongings; (9) Have access to and spend a reasonable sum of his own money; and (10) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes. (e) No right enumerated in subsections (b) or (d) of this section may be limited or restricted except by the qualified professional responsible for the formulation of the client's treatment or habilitation plan. A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional at least every seven days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's record. Restrictions on rights may be renewed only by a written	V 364		

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V 364	Continued From page 25 statement entered by the qualified professional in the client's record that states the reason for the renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal of a restriction of rights, an individual designated by the client shall, upon the consent of the client, be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction or renewal of a restriction of rights and of the reason for it. Notification of the designated individual or legally responsible person shall be documented in writing in the client's record. This Rule is not met as evidenced by: Based on interview and record review, the facility developed policies limiting client rights and therapeutic treatment affecting 2 of 2 audited current clients (Clients #1 and #2). The findings are: Review on 7/5/22 of the Complete Client Intake Packet for Clients #1 and #2 revealed: -Intake packets completed and signed by legal guardians identified client rights limitations including, but not limited to, the following: -Under North Carolina Self Defense Law, employees have the right to use reasonable force against a client in case of client assaulting a staff. "Workers have the right to use reasonable for to defend themselves" (page 54); -Clients are not allowed to wear "billed hats" or earring until they reach Level 2 (page 59);	V 364		

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V 364	Continued From page 26 -Clients must call collect or use a calling card when making any long distance phone call (Clients #1 and #2 have legal guardians who are at least one hour from the facility requiring long distance phone calls) (page 59); -Clients will be assigned yard work for behavioral infractions (page 59); -Clients will be rewarded with "3 hours of free time" for unsupervised activity which can include dating when they reach a satisfactory behavioral status (page 64); -Clients will be given a written assignment or participate in Saturday schooling for behavioral infractions (page 65); -Clients will be assigned 8-16 hours of "community service" at the facility for behavioral infractions (page 66); -Clients will be denied television and snacks for behavioral infractions (page 66); -Behavioral infractions are evaluated on an individualized basis as opposed to a written therapeutic treatment approach to limiting maladaptive behaviors (page 66); -"Ralph" is responsible for ensuring all chores are completed satisfactorily (page 68); -Limit of 1 teaspoon of sugar daily with it only being used for tea, unsweetened cereal or on grapefruit and "that's it: (page 72); -Condiments such as ketchup, ranch dressing, mayonnaise, and salsa can only be used on "normal things" such as "ketchup on burgers but not on chicken, ranch dressing on salads or vegies, not on sandwiches or French fries" and no coffee (page 72); -Additional rights restrictions and limitations are evident throughout the intake packet. Interviews on 6/30/22 with Clients #1 and #2 revealed: -Denied any client rights restrictions were	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080-216	A. BUILDING: _____ B. WING _____	R 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 364	Continued From page 27 implemented at the facility. Interview on 7/6/22 with Client #1's Department of Social Services (DSS) Legal Guardian (LG) revealed: -Was not the DSS worker who signed the intake packet for Client #1; -Was not aware of the items included in the intake packet; -Would follow up with the facility staff to get a copy of the intake packet and ensure Client #1's rights were not being restricted. Attempted interview on 7/6/22 with Client #2's DSS LG was unsuccessful. A phone message was left requesting a return call, but no return call was received. Interview on 7/6/22 with the Qualified Professional #2/Licensee revealed: -The Quality Assurance/Quality Improvement (QA/QI) Consultant wrote the intake packet; -Had concerns about the intake packet; -Did not implement many aspects of treatment identified in the intake packet; -Did not know who "Ralph" was and never employed anyone by that name; -Will work with the QA/QI Consultant to revise the intake packet.	V 364		
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.	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080-216	A. BUILDING: _____ B. WING _____	R 07/07/2022

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V 736	Continued From page 28 This Rule is not met as evidenced by: Based on interview and observation, the facility was not maintained in a safe and orderly manner. The findings are: Observation on 6/23/22 at approximately 9:45am of the facility revealed: -Doorknob on Client #1's bedroom door was loose; -Small hole behind Client #2's bedroom door directly opposite the doorknob; -Broken doorknob with exposed cylinder and no handle on Client #2's bathroom door. Interview on 6/23/22 with Client #1 revealed: -Had to be very careful opening and closing her bedroom door because the doorknob "was close to falling off." Interview on 6/23/22 with Client #2 revealed: -Had to "pull really hard (on the cylinder) to get out of the bathroom"; -Client #1 accidentally caused damage to the wall behind the bedroom door when Client #1 came into the bedroom and "opened the door too hard and too fast." Interview on 7/7/22 with the Qualified Professional #1 (QP#1) and the Qualified Professional #2/Licensee (QP#2/L) revealed: -Would ensure the hole behind Client #2's bedroom door and the two broken doorknobs would be repaired.	V 736		