Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-170	A. BUILDING: _____ B. WING _____	R 08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDREN UNDER CONSTR TREATMENT CENTER, B	42 JEWEL LANE FOUR OAKS, NC 27524

(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 8/4/22. The complaints were substantiated Intake #'s NC00190459, NC00190486, NC00190483 & NC00190434. Intake #NC00191346 was unsubstantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents This facility is licensed for 4 and currently has a census of 4. The survey sample consisted of audits of 3 current clients and 1 former client.	V 000		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred	V 113		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE CEO (X6) DATE 8/22/22

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V 113	Continued From page 1 physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record review and interview the facility failed to maintain a client record for 1 of 1 current client (#1) & 1 of 2 former client (FC#5). The findings are: A. Review on 7/22/22 of client #1's record revealed: - admitted 4/1/22 - age: 11 - diagnoses of Oppositional Defiant Disorder, Adjustment Disorder and Attention Deficit Hyperactivity Disorder - no documentation of respite care in March 2022	V 113	As of 7/22/22 will not admit any crisis respite clients until we have crisis respite added to our license.	7/22/22

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V 113	Continued From page 2 B. Review on 7/28/22 of the Division of Health Service Intake form for FC#5 revealed: - FC#5's name - age: 12 - no diagnoses During interview 7/28/22 the Licensee reported: - client #1 came in March 2022 for respite - was not not approved for authorization by the Local Managed Care/Management Care Organization until 4/1/22 - did not consider client #1 admitted to the facility until 4/1/22 - FC#5 was an emergency respite for approximately 2 weeks in April 2022 - he did not keep a client record for respite clients - he was responsible for ensuring clients had a record	V 113	As of 7/22/22 will not admit any crisis respite clients until we have crisis respite added to our license.	7/22/22
V 138	27G .0404 (A-E) Operations During Licensed Period 10A NCAC 27G .0404 OPERATIONS DURING LICENSED PERIOD (a) An initial license shall be valid for a period not to exceed 15 months from the date on which the license is issued. Each license shall be renewed annually thereafter and shall expire at the end of the calendar year. (b) For all facilities providing periodic and day/night services, the license shall be posted in a prominent location accessible to public view within the licensed premises. (c) For 24-hour facilities, the license shall be available for review upon request. (d) For residential facilities, the DHSR complaint hotline number shall be posted in a public place	V 138		

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V 138	Continued From page 3 in each facility. (e) A facility shall accept no more clients than the number for which it is licensed. This Rule is not met as evidenced by: Based on record review and interview the facility failed to accept no more clients than the number for which it was licensed for affecting 4 of 4 current clients (#1, #2, #3 & #4) and 1 of 2 former client (FC#5). The findings are: Review on 7/22/22 of client #1's record revealed: - admitted 4/1/22 - age: 11 - diagnoses of Oppositional Defiant Disorder, Adjustment Disorder and Attention Deficit Hyperactivity Disorder (ADHD) - no documentation of respite care in March 2022 Review on 8/4/22 of client #2's record revealed: - admitted 10/30/20 - diagnoses of Reactive Attachment Disorder - age: 10 Review on 7/22/22 of client #3's record revealed: - admitted 4/9/20 - diagnoses of ADHD & Post Traumatic Stress Disorder - age: 16 Review on 7/22/22 of client #4's record revealed: - admitted 6/3/19 - age: 15 - diagnoses of Conduct Disorder & ADHD	V 138	As of 7/22/22 will not admit any crisis respite clients until we have crisis respite added to our license.	7/22/22

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V 138	Continued From page 4 Review on 7/28/22 of Division of Health Service Intake form for FC#5 revealed: - FC#5's name - age: 12 - no diagnoses - admitted to the facility between April 2022 - May 2022 During interview on 8/2/22 the Qualified Professional reported: - there were 4 boys at the facility when FC#5 was admitted - stayed at the facility 2 - 3 weeks - he left and returned backed to the facility for 2 - 3 more nights because the placement did not work out During interview on 8/4/22 the Licensee reported: - FC#5 was an emergency respite client - came for a week in April 2022 and discharged to placement - the placement did not work out and was readmitted for another week - he did not keep a client record for respite clients - would not admit clients above what he was licensed for in the future	V 138	As of 7/22/22 will not admit any crisis respite clients until we have crisis respite added to our license.	7/22/22
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:	V 366		

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V 366	Continued From page 5 (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. (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	V 366		

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V 366	Continued From page 6 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 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;	V 366		

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V 366	Continued From page 7 (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 record review and interview the facility failed to implement their incident reporting policy. The findings are: Refer to V367 regarding details of incidents that occurred at the facility - police calls to the facility - client #1 placed in a restraint by the Licensee During interview on 7/28/22 the License reported: - he was aware of the police calls - verified he placed client #1 in a restraint - did not complete Level II incident reports - responsible for investigating incidents and submitting in the incident response improvement system	V 366	As of 7/22/2022 staff at Children Under Construction will no longer use restrictive interventions. On 8/13/22 refresher course on NCI was completed with additional prevention and defensive portion for all staff members.	7/22/22
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	V 367		

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V 367	Continued From page 8 level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that 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;	V 367		

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V 367	Continued From page 9 (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III 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.	V 367		

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V 367	Continued From page 10 This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure Level II incident reports were submitted within 72 hours to the Local Management Care/Managed Care Organization. The findings are: Review on 7/22/22 of the incident response improvement system (IRIS) revealed: - last submission of an incident was 7/28/20 During interview on 7/22/22 client #1 reported: - he eloped from the facility in April 2022 - returned to the facility and attempted to destroy property in his bedroom - was placed in a face down restraint by the Licensee During interview on 7/22/22 staff #3 reported: - police was contacted for client #4 either April 2022 or May 2022 - she thought he had left the premises but he had hid under the facility During interview on 7/22/22 staff #2 reported: - client #3 eloped from the facilty September & December 2021 - the police was contacted During interview on 7/28/22 & 8/4/22 the Licensee reported: - verified he placed client #1 in a face down restraint - restraint happened in March 2022 & client #1 was a respite client	V 367	As of 8/13/22 all staff were notified that any time the police are called to complete an incident report within 24 hours to ensure the iris report can be completed within 72 hours. As of 7/22/2022 staff at Children Under Construction will no longer use restrictive interventions. On 8/13/22 refresher course on NCI was completed with additional prevention and defensive portion for all staff members.	8/13/22

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V 367	Continued From page 11 - did not complete a level II incident report because he was respite - aware of police calls to facility - he was responsible for the completion of incident reports & submission through the IRIS system	V 367		
V 518	27E .0104(e1-2) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (1) the requirement that positive and less restrictive alternatives are considered and attempted whenever possible prior to the use of more restrictive interventions; (2) consideration is given to the client's physical and psychological well-being before, during and after utilization of a restrictive intervention, including: (A) review of the client's health history or the client's comprehensive health assessment conducted upon admission to a facility. The health history or comprehensive health assessment shall include the identification of pre-existing medical conditions or any disabilities and limitations that would place the client at greater risk during the use of restrictive interventions; (B) continuous assessment and monitoring of the physical and psychological well- being of the client and the safe use of restraint throughout the duration of the restrictive intervention by staff who are physically present and trained in the use of emergency safety interventions;	V 518		

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V 518	Continued From page 12 (C) continuous monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being during the use of manual restraint; and (D) continued monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being for a minimum of 30 minutes subsequent to the termination of a restrictive intervention; This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure continuous assessment and monitoring of the physical and psychological well being of the client and the safe use of a restraint by a staff who was physically trained in the use of emergency safety interventions by 1 of 3 audited staff (Licensee). The findings are: Review on 7/22/22 of client #1's record revealed: - admitted 4/1/22 - age: 11 - diagnoses of Oppositional Defiant Disorder, Adjustment Disorder and Attention Deficit Hyperactivity Disorder (ADHD) - no documentation of respite care in March 2022 During interview on 7/22/22 & 7/28/22 client #1 reported: - eloped from the facility in April 2022 - returned to the facility and attempted to destroy property in his bedroom - was placed on the floor face down and 1 hand behind his bed by the Licensee - was able to turn his face from side to side	V 518	As of 7/22/2022 staff at Children Under Construction will no longer use restrictive interventions. On 8/13/22 refresher course on NCI was completed with additional prevention and defensive portion for all staff members.	

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V 518	Continued From page 13 - the restraint lasted less than a minute During interview on 8/2/22 the facility's NCI+ (North Carolina Intervention) trainer reported: - the facility's staff were trained in NCI + (prevention) which were de-escalation techniques - staff were not trained in any physical restraints During interview on 7/28/22 & 8/4/22 the Licensee reported: - verified he placed client #1 in a face down restraint - verified he was trained in the de-escalation techniques - client #1 attempted to elope a second time, the same day, from the facility - destroyed property in his bedroom - client #1 was placed in a restraint for his safety - did not complete any documentation about the restraint - restraint happened in March 2022 - client #1 was a respite client & was not admitted to the facility	V 518		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated	V 537		

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CHILDREN UNDER CONSTR TREATMENT CENTER, B	42 JEWEL LANE FOUR OAKS, NC 27524

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V 537	Continued From page 14	V 537		

competence at least annually.
(b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated.
(c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions.
(d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(e) Formal refresher training must be completed by each service provider periodically (minimum annually).
(f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.
(g) Acceptable training programs shall include, but are not limited to, presentation of:
(1) refresher information on alternatives to the use of restrictive interventions;
(2) guidelines on when to intervene (understanding imminent danger to self and others);
(3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention);
(4) strategies for the safe implementation

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V 537	Continued From page 15 of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or	V 537		

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V 537	Continued From page 16 failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time.	V 537		

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V 537	Continued From page 17 (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on observation, record review and interview 3 of 5 facility staff (#1, #2 & Licensee) utilized restrictive intervention for which they were not trained & the facility failed to ensure 1 of 1 Qualified Professional (QP) demonstrated competency. The findings are: Review on 8/4/22 of the facility's restrictive intervention policy revealed: "...committed to providing quality services in the least restrictive manner...staff will only use interventions approved by the company for which they receive appropriate training...the determination that a behavior intervention is indicated and the authorization for the use of such treatment for a specific resident shall only be made by a professional who has been formally trained in the use of the intervention...the following interventions are approved for use in Children Under Construction, Barnes Inc. residential facility...physical restraint - only to terminate a behavior or action in which a resident is in imminent danger of abuse or injury to self or others or when substantial property damage is	V 537	As of 7/22/2022 staff at Children Under Construction will no longer use restrictive interventions. On 8/13/22 refresher course on NCI was completed with additional prevention and defensive portion for all staff members.	8/13/22

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V 537	Continued From page 18 occurring..." Review on 7/28/22 & 8/4/22 of staff #1, #2, & Licensee's personnel records revealed: - all were trained in NCI+ (North Carolina Intervention) (prevention) Review on 7/28/22 of the QP's personnel record revealed: - was trained in NCI+ prevention & defensive Review on 7/22/22 of client #1's record revealed: - admitted 4/1/22 - age: 11 - diagnoses of Oppositional Defiant Disorder (ODD), Adjustment Disorder and Attention Deficit Hyperactivity Disorder (ADHD) Observation on 7/22/22 at 4:02pm of client #1's bedroom revealed carpet flooring During interview on 7/22/22 & 7/28/22 client #1 reported: - eloped from the facility in April 2022 - returned to the facility and attempted to destroy property in his bedroom - the Licensee attempted to do a "face down restraint" on his bed but did not want to break his bed - was then placed "on the floor face down with 1 hand behind my back" - was able to turn his face from side to side - could not recall the clients that told him "you had carpet therapy" - "carpet therapy" meant "put down on the floor" in a restraint During interview & observation at 2:22pm on 7/28/22 client #3 reported: - denied being put in any restraints	V 537		

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V 537	Continued From page 19 - heard of carpet therapy but not sure where he heard it from - carpet therapy was when "you get put down on the floor" - he would demonstrate carpet therapy: got on the floor face down - could turn your face from side to side During interview on 7/22/22 staff #2 reported: - floor restraints were not taught in NCI+ prevention - was told if a client charged at staff, "staff could mush them in their face with the palm of their hands to prevent the attack" - she had not conducted this restraint During interview on 8/2/22 staff #1 reported: - if client #3 had a behavior, she held his hands by his side and escorted him to his bedroom - she was trained to place his hands in front of him in a wrap position, however, "he was like 220 pounds" and she could not get his arms in front of him - clients in the past told her they "were put down" - "guess that meant a restraint" - did not ask what "put down" meant - "don't know if it meant to be escorted" - she asked the clients "what they did to get put down?" - could not recall what clients told her as to why they were "put down" - had not witnessed a "put down" During interview on 8/2/22 the facility's NCI+ trainer reported: - the facility's staff were trained in NCI+ (prevention) which were de-escalation techniques - staff were not trained in any physical restraints	V 537		

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V 537	Continued From page 20 - "no floor techniques" were taught in any of NCI+ trainings - floor restraints had not been conducted since 2012 or 2013 due to the number of deaths During interview on 8/2/22 the NCI+ Instructor reported: - helped develop the NCI+ program - no floor restraints were taught, only standing restraints - have not heard of carpet therapy - NCI+ techniques did not include placing a client's arms behind their back - there were no NCI+ techniques taught to "mush a client in the face" during a charge - "you do not hit a client" - if a client charged, then "move out of the way" - "did away with floor restraints years ago" - a therapeutic wrap was a technique - the arms are wrapped in front of the client below the rib cage to allow breathing During interview on 8/2/22 the Qualified Professional reported: - was contacted twice in the last 2 months by staff #1 in regards to restraints - staff #1 called and said she had to "put him (client #3) down" - was not sure what "put down" meant, "sit client on the floor maybe?" - had not witnessed any clients being "put down" - she was trained in physical restraints but was able to calm clients' behaviors without physical restraints - a face down restraint was not a technique taught in NCI+ During interview on 7/28/22 & 8/4/22 the Licensee reported:	V 537		

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V 537	Continued From page 21 - he placed client #1 in a restraint in March 2022 - client #1 attempted to elope a second time, the same day, from the facility - he destroyed property in his bedroom - client #1 was placed in a restraint face down on his bedroom floor - he placed both his arms under him, to lift client #1 off the floor, this prevented his face from being near the floor - the restraint was less than 1 minute - the restraint was for client #1's safety - it had been years since he used the words "carpet therapy" - "carpet therapy was a face down restraint" - he used the term "carpet therapy, not as a threat but to calm a client's behavior" Review on 8/4/22 of the Plan of Protection dated 8/4/22 written by the Licensee revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? My immediate action on August 4th, 2022, we will not use physical interventions. We will only use prevention methods which excludes from physical restraints. We will contact our NCI instructor today August 4th, 2022, to set up a time for a refresher course. Describe your plans to make sure the above happens. The Owner/CEO will make sure the above statements happen." Client #1 was admitted to the facility with diagnoses of ODD, Adjustment Disorder and ADHD. He was placed in an unapproved face down restraint with one hand behind his back by the Licensee. Staff #1 would hold client #3's hands by his side to calm his behaviors. Staff #2 would mush a client in the face with the palm of her hands if they charged at her. The facility's staff utilized physical restraints, even though, they	V 537		

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V 537	Continued From page 22 were only trained in de-escalation techniques. The QP was made aware physical restraints were being utilized, however, did not follow up with staff about how the physical restraints were being conducted. Based on staff not being trained in physical restraints and utilizing techniques that were not approved as restrictive interventions, 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 is imposed for failure to correct within 45 days.	V 537		
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: Based on observation and interview the facility failed to maintain its grounds in a safe, attractive and orderly manner. The findings are: Observation on 8/4/22 of the facility between 12:54pm & 12:57pm revealed the following: - kitchen area: - laminate peeled away from the outside of the countertops - a missing glass pane from a window that obtained 6 glass panes	V 736	As of 8/22/22, a handy man has been hired and started working. The windows that were ordered to replace the window with a missing glass pane was too small. The windows are backordered at the moment. The kitchen repairs will be complete by 8/30/22	

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V 736	Continued From page 23 - the missing glass pane was covered with cardboard & boarded with yellow tape - client #3 & #4's bedroom: - a hole the size of a quarter in the upper left corner of their bedroom door - client #4 had a white paint spot the size of a baseball on the wall near his bed During interview on 8/4/22 the Licensee reported: - the clients had behaviors and caused damage to the facility - client #3 had a behavior 6 months ago and threw something & broke the glass pane - ordered the glass pane and it came June 2022 but it did not fit and had to be re-ordered - will ensure repairs at the facility were completed This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736	Handyman will complete the work on the holes on the walls and do some paint retouching by 8/30/22	
V 766	27G .0304(d)(3) Not More Than Two Clients 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (d) Indoor space requirements: Facilities licensed prior to October 1, 1988 shall satisfy the minimum square footage requirements in effect at that time. Unless otherwise provided in these Rules, residential facilities licensed after October 1, 1988 shall meet the following indoor space requirements: (3) No more than two clients may share an individual bedroom regardless of bedroom size.	V 766		

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V 766	Continued From page 24 This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 2 clients shared a bedroom regardless of the bedroom size affecting 2 of 2 current clients (#3 & #4) & 1 of 2 former client (FC#5). The findings are: Review on 7/22/22 of client #3's record revealed: - admitted 4/9/20 - diagnoses of Attention Deficit Hyperactivity Disorder (ADHD) & Post Traumatic Stress Disorder - age: 16 Review on 7/22/22 of client #4's record revealed: - admitted 6/3/19 - age: 15 - diagnoses of Conduct Disorder & ADHD Review on 7/28/22 of Division of Health Service Intake form for FC#5 revealed: - FC#5's name - age: 12 - no diagnoses - admitted to the facility between April 2022 - May 2022 During interview on 8/2/22 the Qualified Professional reported: - FC#5 initially slept on a "blow up" mattress in client #3 & #4's bedroom - they had a huge bedroom - later requested to sleep on the "blow up" mattress in the television room During interview on 8/4/22 the Licensee reported: - FC#5 was an emergency respite client in April 2022 - slept on a "blow up" mattress in client #3 &	V 766	As of 7/22/22 will not admit any crisis respite clients until we have crisis respite added to our license.	

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V 766	Continued From page 25 #4's bedroom but did not want to be in their bedroom - slept on a "blow up" mattress in the television room - will ensure no more than 2 clients were in a bedroom	V 766		
V 774	27G .0304(d)(7) Minimum Furnishings 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (d) Indoor space requirements: Facilities licensed prior to October 1, 1988 shall satisfy the minimum square footage requirements in effect at that time. Unless otherwise provided in these Rules, residential facilities licensed after October 1, 1988 shall meet the following indoor space requirements: (7) Minimum furnishings for client bedrooms shall include a separate bed, bedding, pillow, bedside table, and storage for personal belongings for each client. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 1 of 2 former client (FC#5) had minimum furnishings. The findings are: Review on 7/28/22 of Division of Health Service Intake form for FC#5 revealed: - FC#5's name - age: 12 - no diagnoses - admitted to the facility between April 2022 - May 2022	V 774		

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V 774	Continued From page 26 During interview on 8/2/22 staff #1 reported: - FC#5 slept on a "blow up" mattress in the television room During interview on 8/2/22 the Qualified Professional reported: - FC#5 initially slept on a "blow up" mattress on the floor in client #3 & #4's bedroom - later requested to sleep on the "blow up" mattress in the television room - was at the facility for 2 - 3 weeks & discharged to placement - the placement did not work out and returned for 2 - 3 more nights During interview on 8/4/22 the Licensee reported: - FC#5 was a emergency respite client in April 2022 - slept on a "blow up" mattress in the television room - will ensure all clients have a bedroom with furnishing This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 774	As of 7/22/22 will not admit any crisis respite clients until we have crisis respite added to our license.	
V 784	27G .0304(d)(12) Therapeutic and Habilitative Areas 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (d) Indoor space requirements: Facilities licensed prior to October 1, 1988 shall satisfy the minimum square footage requirements in effect at that time. Unless otherwise provided in these Rules, residential facilities licensed after October 1, 1988 shall meet the following indoor space	V 784		

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CHILDREN UNDER CONSTR TREATMENT CENTER, B	42 JEWEL LANE FOUR OAKS, NC 27524

(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 784	Continued From page 27 requirements: (12) The area in which therapeutic and habilitative activities are routinely conducted shall be separate from sleeping area(s). This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure therapeutic and habilitative activities were conducted separately from sleeping areas for 1 of 2 former client (FC#5). The findings are: Review on 7/28/22 of Division of Health Service Intake form for FC#5 revealed: - FC#5's name - age: 12 - no diagnoses - admitted to the facility between April 2022 - May 2022 During interview on 8/2/22 staff #1 reported: - FC#5 slept on "blow up" mattress in the television room - did not allow him to sleep in bedroom with other clients because she did not have any information about him - no diagnoses or background information for FC#5 - was supposed to stay for the weekend but stayed 2 - 3 weeks During interview on 8/2/22 the Qualified Professional reported: - FC#5 initially slept on a "blow up" mattress in client #3 & #4's bedroom - later requested to sleep on the "blow up" mattress in the television room - stayed at the facility between 2 - 3 weeks - left and returned back to the facility for 2 - 3	V 784	As of 7/22/22 will not admit any crisis respite clients until we have crisis respite added to our license.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-170	A. BUILDING: _____ B. WING _____	R 08/04/2022

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V 784	Continued From page 28 more nights because the placement did not work out During interview on 8/4/22 the Licensee reported: - FC#5 was a emergency respite client - came for a week in April 2022 and was discharged to another placement - the placement did not work out and was readmitted for another week - slept on a "blow up" mattress in the television room - will ensure all clients have a bedroom	V 784		