AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		SURVEY PLETED
		MHL060-776	B. WING		0.3	R /23/202
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E ZIP CODE	1 03	1231202
NEW PLA	CF		ULCONBRIDGE R			
	T		OTTE, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD RE	COMI DA
V 000	INITIAL COMMENTS	3	V 000			
	An annual, complaint completed on 3/23/22 unsubstantiated (NC NC00186732). Defici	and follow up survey were 2. The complaints were 00185926 and encies were cited.				
	category: 10A NCAC	f for the following service 27G .1700 Residential		DHSR - Mental Heal	th	
	Treatment Staff Securion Adolescents.	re for Children or		APR 27 2022		
	census of 2. The survi	d for 4 and currently has a ey sample consisted of ents and 1 former client.		Lic. & Cert. Section		
V 118	27G .0209 (C) Medica	tion Requirements	F-V 118			
	10A NCAC 27G .0209 REQUIREMENTS	MEDICATION				
	(c) Medication adminis	tration:				
((1) Prescription or non	-prescription drugs shall				
(only be administered to	a client on the written				
C	order of a person author	orized by law to prescribe				
	drugs.					
(lients only when and	e self-administered by				
0	clients only when authorilient's physician.	Drized in writing by the				
	 Medications, includi 	ng injections, shall be			8 0	
а	dministered only by lic	censed persons, or by				
u	nlicensed persons trai	ned by a registered nurse.				
p	narmacist or other leg	ally qualified person and				
(4	1) A Medication Admin	nd administer medications. istration Record (MAR) of				
a	Il drugs administered t	o each client must be kept				
CI	urrent. Medications ad	ministered shall be				
re	ecorded immediately a	fter administration. The				
	IAR is to include the fo	llowing:				
	A) client's name; B) name, strength, and	quantity of the deve				
(0	c) instructions for admi	nistering the drug;				
of Health	Service Regulation					
TORY DIRE	CIOR'S OR PROVIDER/SUP	PLIER REPRESENTATIVE'S SIGNATURE		TITLE	(Ve	DATE
1/10	11/	Exervative	Director		12027) DATE
ORM			6899 LEXS		12027	

	Divisio	n of Health Service Reg	ulation			FORM	MAPPROVED
I	STATEME	ENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	T	
l	AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER:	1	S:	(X3) DATE S	
l					··		
l			MHL060-776	B. WING		F	3
r			1 11112000-770			03/2	23/2022
l	NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
	NEW PL	ACE	5601 FA	ULCONBRIDGE	ROAD		
L			CHARL	OTTE, NC 2822	7		
	(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	
	PREFIX TAG	REGULATORY OR	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BF	(X5) COMPLETE
				TAG	CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	RIATE	DATE
	V 11	8 Continued Face					
		Continued From page	9 1	V 118			
		(D) date and time the	drug is administered; and				
		(E) name or initials of	person administering the				
		drug.					
		(5) Client requests for	r medication changes or				
		checks shall be recor	ded and kept with the MAR				- 1
		file followed up by app	pointment or consultation				
		with a physician.			2		- 1
							1
							- 1
							- 1
							- 1
		This Rule is not met a	as evidenced by:		is		
		Based on record revie	w, observations and				- 1
		interviews, the facility	failed to ensure a MAR of				1
		medications administe	red to each client was kept		2		- 1
			ns were administered as	-			1
		ordered affecting 1 of	2 clients (client #2). The				
		findings are:					- 1
		Record review of clien	t #210 record				- 1
		- Admissions date 3/25	5/20				- 1
		- Age 15;	5720,				1
		- Diagnoses Disruptive	Mond Dysregulation				- 1
		Disorder; Post Trauma	tic Stress Disorder:				- 1
		- Physician orders date	ed 9/9/21 omeprazole				
		delayed release (DR)(h	neartburn) 10				- 1
		milligram(mg), Take on	e capsule by mouth every				- 1
		morning; Prazosin(urina	ary retention) 2 mg				- 1
		capsule, Take one caps	sule by mouth twice daily;				
		- Physician order dated	5/6/21 omeprazole Dr 20				
		mg, Take one capsule to	by mouth daily;				1
		-Physician order dated	11/30/21				
		thin layer to the effect	tis) 0.1% cream, Apply a				
		thin layer to the affected	area twice daily;				
		 Physician order dated Fumarate(mood disorder 	or/ 200 mg. Toke				
		tablet by mouth every d	avat7nm				
		by mouth every d	ay at / pill.	1			1

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED R B. WING MHL060-776 03/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5601 FAULCONBRIDGE ROAD **NEW PLACE** CHARLOTTE, NC 28227 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 118 | Continued From page 2 V 118 - Physician order dated 8/20/21 Vitamin D2 1.25 mg, take one capsule by mouth every week. Observations on 2/25/22 at approximately 1:00pm of client #2's medication's revealed: -There was no omeprazole Dr 20 mg; Triamcinolone 0.1% cream and Vitamin D2 1.25mg to observe in the facility. Review on 2/25/22 of client #2's MARs from December 2021-February 2022 revealed: -The date of 12/31/21 for the am dose was left blank with no explanation on the MAR for the following medications: omeprazole Dr 20 mg.; omeprazole Dr 10mg, Prazosin 2 mg,; Triamcinolone 0.1% cream: -The date of 12/31/21 for the pm dose was left blank with no explanation on the MAR for the following medications: Prazosin 2 mg capsule; Quetiapine Fumarate 200 mg, Triamcinolone 0.1% cream; -The date of 1/31/22 for the pm dose was left blank with no explanation on the MAR for the following medications: Prazosin 2 mg; Quetiapine Fumarate 200 mg, Triamcinolone 0.1% cream; - Vitamin D2 1.25 mg, was initialed daily for January through February 25, 2022. Interview on 2/24/22 with client #2 revealed: -Was adminstered all medications daily from staff: -Denied any medications errors. Interview on 2/25/22 with Qualified Professional/ Executive Director revealed: -Unable to provide an explanation for the medication errors; -"I would need to speak with the staff." - Oversee the MARs.

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED R MHL060-776 B. WING 03/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5601 FAULCONBRIDGE ROAD **NEW PLACE** CHARLOTTE, NC 28227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 118 | Continued From page 3 V 118 Due to the failure to accuratley document medication adminstration, it could not be determined if clients received their medications as ordered by the physicians. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. V 131 G.S. 131E-256 (D2) HCPR - Prior Employment V 131 Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to access the Health Care Personnel Registry (HCPR) prior to offer of employment affecting 1 of 5 staff (staff #2). The findings are: Review on 2/25/22 of staff #2's personnel record revealed: - Date of hire 11/16/10; -There was no HCPR in file to show it was assessed before employment.

Division of Health Service Regulation

Interview on 3/22/22 with the Qualified

LEXS11

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY
		MHL060-776	B. WING		03	R /23/2022
NAME OF PROVID	ER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE	•	
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NEW TEACE		CHARLO	OTTE, NC 28227			
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V 131 Con	tinued From page	4	V 131			
- HC - Un - HC	PR was not in sta able to locate the	from personnel file at some				
	.1706 Residentia rations	Tx. Child/Adol -	V 298			
(a) of 12 (b) I pers in or restr (c) The shall to end the transfer pers (d) Freed (e) If receipt for six year, (f) Esage-a entitle plan.	2 children and additionally members of consistent plan. The residential treation and additional treation and additional treation and additional treation attend school; it dinate services active learning producement. Psychiatric consulting treatment in the anadolescent having treatment in the amount of an adolescent having treatment in the amount of a counter-interest and a counte	serve no more than a total elescents. or other legally responsible and in development of plans and transition to a less elected at the secure facility are local education agency also educational needs are child's educational needs are child's education plan and post of the children will be for others, the facility will ross settings such as agrams, day treatment, or a lation shall be available as or adolescent. Is his 18th birthday while the facility, he may remain the end of the state fiscal				

Division	of Health Service Reg	ulation			FOR	MAPPROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY
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I WANTE OF I	NOVIDER OR SUPPLIER		DDRESS, CITY, STAT			
NEW PLA	ACE		ULCONBRIDGE R OTTE, NC 28227	OAD		
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V 298	Continued From page	e 5	V 298			
					1.50	
	This Date is a first					
	This Rule is not met	as evidenced by: ew and interview, the facility				
	allowed a client to ren	main in the facility in excess				
	of the maximum allow	ved time of six months				
	following clients 18th	birthday or until end of the				
	state fiscal year affect The findings are:	ting 1 of 2 clients (client #1).				
	The indings are.					
	Review on 2/25/22 of	client #1's record revealed:				
	- Date of admission 7					
		epression, recurrent, severe				
	with episodic suicidal Post-Traumatic Stress	Disorder; Psychosis, not				
		autism Spectrum Disorder				
	with Intellectual Defici	ts, Intermittent Explosive				
	Disorder; - Age 19;					
	- Client was under the	guardianship of the				
	Department of Social	Services (DSS) in her home				
	county prior to 18th bir	rthday;				14
		entered profile (PCP) dated				
	to stay in DSS custody	#2's long range outcome is				
	Interview on 2/24/22 w					
	- She turned 19 in Octo					
	- Flamled to live at an	independent living facility.				
		ith Qualified Professional				
	#1/Executive Director r	revealed:				
	- No waiver was compl					
	- "Actively trying to find to go."	her (client #1) somewhere				- 1
		d client #1 a placement				
	due to behaviors;					
	- Client #1 recently had	an interview at an				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED MHL060-776 B. WING 03/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5601 FAULCONBRIDGE ROAD **NEW PLACE** CHARLOTTE, NC 28227 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)**PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 298 Continued From page 6 V 298 independent living facility; - Client #1 "went today for a psychological evaluation." - Client #1 has nowhere to go if she was discharged today. V 367 27G .0604 Incident Reporting Requirements V 367 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; status of the effort to determine the (5)cause of the incident; and 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

LEXS11

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY MPLETED
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V 367	Continued From page	e 7	V 367			
	day whonover		=			
	information provided in erroneous, misleading (2) the provider	g or otherwise unreliable; or obtains information				
	unavailable. (c) Category A and B upon request by the L obtained regarding the	e incident, including:				
	information; (2) reports by or (3) the provider'	ther authorities; and s response to the incident.				
	of all level III incident in Mental Health, Develo Substance Abuse Sen becoming aware of the providers shall send a	providers shall send a copy reports to the Division of pmental Disabilities and vices within 72 hours of a incident. Category A copy of all level III lient death to the Division of				
	Health Service Regula becoming aware of the client death within seve or restraint, the provide immediately, as require .0300 and 10A NCAC 2 (e) Category A and B	tion within 72 hours of a incident. In cases of the days of use of seclusion for shall report the death and by 10A NCAC 26C 27E .0104(e)(18).				
	catchment area where The report shall be sub by the Secretary via ele include summary inform (1) medication er definition of a level II or (2) restrictive inte the definition of a level (3) searches of a	services are provided. mitted on a form provided ectronic means and shall nation as follows: rors that do not meet the level III incident; erventions that do not meet				

Division	of Health Service Reg	ulation			FOR	MAPPROVED
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	12 DOM: 1000-1000-1000-1000-1000-1000-1000-100	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		MHL060-776	B. WING			R 23/2022
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	ATE, ZIP CODE	1 00/	LOTEUZZ
NEW PLA	ACE	5601 FA	ULCONBRIDGE	ROAD		
		CHARL	OTTE, NC 28227			
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V 367	Continued From page	e 8	V 367			
	incidents that occurre	mber of level II and level III d; and indicating that there have				*
	incidents have occurr meet any of the criter	ed during the quarter that ia as set forth in Paragraphs e and Subparagraphs (1)				e a
						÷
	failed to ensure incide Local Mangement Ent area where services a	as evidenced by: w and interview, the facility nts were reported to the ity(LME) for the catchment re provided within 72 hours the incident. The findings				
	revealed: - Date of admission 7/6 - Diagnoses- Major De with episodic suicidal in Post-Traumatic Stress otherwise specified; Au	pression, recurrent, severe				
	Review of North Caroli Improvement System (revealed: -There was no docume report for client #1 in IR	IRIS) 2/28/22 and 3/21/22				

Division	of Health Service Regu	lation			FOF	RM APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
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NEW LE		CHARL	OTTE, NC 28227			
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V 367	Continued From page	9	V 367			
	- "Staff left me and I w - "I left the home(facili - "I went to staff's hom - "Staff threaten to hit - Police called to the h - Went to local hospita - Denied property dam Interview on 2/24/22 w - Client #1 wanted to I leave with staff; - Client #1 found a ride - Staff's husband didn' - Client #1 found a way - Client #1 caused pro home; - Police were called to - Client #1 went to the - Client #1 wants to live	ty)."; ie."; me in the head."; iome; il; nage to staff's home. with client #2 revealed: eave with staff but unable to e to staff's house; t let her in their home; y into staff's home; perty damage in the staff's the home; hospital;				
	property on yesterday (- Client #1 attempted to well; - Client #1 ran away an - Client #1 got into the sigarage; - Client #1 destroyed the Police were called; - Client #1 stated that sherself;	#1/Executive director strained due to destroying (2/24/22); o assault an employee as d went to the staff's home; staff's home through the se property at staff's home; he was going to harm sen to the hospital by the				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R B. WING MHL060-776 03/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5601 FAULCONBRIDGE ROAD **NEW PLACE** CHARLOTTE, NC 28227 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) V 367 Continued From page 10 V 367 - Client #1 was discharged from hospital the next morning (2/25/22); - Forgot to put incident report in IRIS. V 736 27G .0303(c) Facility and Grounds Maintenance V 736 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 observations and interviews, the facility failed to be maintained a safe, clean, attractive and orderly manner. The findings are: Observations on 2/25/22 at approximately 1:46pm revealed the following: - Vent covers throughout the facility were rusted and dented: - Bathroom in hallway has a crack approximately 5 inches long in the door; - Light switch fixture was missing in client #2's - Broken sink with triangle shape piece of tile missing from sink in the bathroom connected to the last bedroom on the left; - There were about 5 paint spots on the floor in former client #3's room. Interview on 2/25/22 and 3/23/22 with the Qualified Professional #1/Executive Director revealed:

Division	of Health Service Regu	ulation					FORM APPROVED
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/O	CLIA ER:	1 111100 100	PLE CONSTRUCTION	(X	3) DATE SURVEY
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V 736	Continued From page	11		V 736			
	- Vents are old and ur	nable to find vents to					
	replace; - Made some improve	ements to the home alrea	adv.				
	- Plan to start on the r	repairs.	uuy,				
	This deficiency consti	tutes a re-cited deficienc	CV		,		
	and must be corrected	d within 30 days.	- ,				
					**		
					2		
							·

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED R MHL060-776 B. WING 03/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5601 FAULCONBRIDGE ROAD **NEW PLACE** CHARLOTTE, NC 28227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 An annual, complaint and follow up survey were completed on 3/23/22. The complaints were unsubstantiated (NC00185926 and NC00186732). 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 2. The survey sample consisted of audits of 2 current clients and 1 former client. V 118 27G .0209 (C) Medication Requirements V 118 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: (C) instructions for administering the drug:

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

	of Health Service Regu				, ,	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY IPLETED
		MHL060-776	B. WING		03	R 3/23/2022
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NEW PLA	CE		OTTE, NC 28227	JAU		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	1	V 118			
	(D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be record file followed up by app	drug is administered; and person administering the medication changes or ded and kept with the MAR pointment or consultation				
	with a physician.					
						2
	medications administer current and medication					
	mango aro.					
	Record review of client - Admissions date 3/25 - Age 15; - Diagnoses Disruptive Disorder; Post Traumat - Physician orders (SD)(Mood Dysregulation tic Stress Disorder; d 9/9/21 omeprazole				
. 1	morning; Prazosin(urina capsule, Take one caps	e capsule by mouth every ary retention) 2 mg sule by mouth twice daily; 5/6/21 omeprazole Dr 20 by mouth daily;				
t -		is) 0.1% cream, Apply a d area twice daily; 8/24/20 Quetiapine er) 200 mg, Take one				

Division	of Health Service Regu	ulation			FORM APPROVED
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL060-776	B. WING		R 03/23/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STAT	E ZIP CODE	1 03/23/2022
NEW S. A			ULCONBRIDGE R		
NEW PLA	ICE		OTTE, NC 28227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
V 118	Continued From page	2	V 118		
	- Physician order date	ed 8/20/21 Vitamin D2 1.25 by mouth every week.			
	Observations on 2/25 1:00pm of client #2's in There was no omepro Triamcinolone 0.1% of 1.25mg to observe in	medication's revealed: azole Dr 20 mg; ream and Vitamin D2			
	December 2021-Febru-The date of 12/31/21 blank with no explanation following medications: omeprazole Dr 10mg, Triamcinolone 0.1% cr	for the am dose was left tion on the MAR for the omeprazole Dr 20 mg,; Prazosin 2 mg,; ream;			
	blank with no explanat following medications: Quetiapine Fumarate 2 0.1% cream;	for the pm dose was left ion on the MAR for the Prazosin 2 mg capsule; 200 mg, Triamcinolone or the pm dose was left			
	blank with no explanat following medications:	ion on the MAR for the Prazosin 2 mg; Quetiapine Imcinolone 0.1% cream; was initialed daily for			
	Interview on 2/24/22 w -Was adminstered all n staff; -Denied any medication	nedications daily from			
		th Qualified Professional/ aled: explanation for the			

Division	of Health Service Regu	ulation			FOR	MAPPROVED	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE	SURVEY	
		MHL060-776	B. WING			R 03/23/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE ZIP CODE	1 00/	LUIZUZZ	
			ULCONBRIDGE				
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V 118	Continued From page	9 3	V 118				
	as ordered by the phy	tion, it could not be eceived their medications vsicians.					
	This deficiency consti and must be corrected	tutes a re-cited deficiency d within 30 days.					
V 131	G.S. 131E-256 (D2) F Verification	ICPR - Prior Employment	V 131				
	REGISTRY (d2) Before hiring hea health care facility or shealth care facility sha	Ith care personnel into a service, every employer at a all access the Health Care ad shall note each incident priate business files.					
						9	
	failed to access the He Registry (HCPR) prior	w and interview, the facility			,		
	Review on 2/25/22 of s revealed: - Date of hire 11/16/10 -There was no HCPR i assessed before emplo	n file to show it was					
	Interview on 3/22/22 w	ith the Qualified				220	

Division	of Health Service Regu	ulation			FOR	RMAPPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Farmous and a second	LE CONSTRUCTION		SURVEY
		MHL060-776	B. WING		03	R / 23/2022
NAME OF F	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, ST	FATE, ZIP CODE	1 00	LOILOLL
NEW PLA	CF		ULCONBRIDGE			
		CHARLO	OTTE, NC 2822	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 131	Continued From page	9.4	V 131			
	- HCPR was not in str - Unable to locate the	from personnel file at some				
V 298	27G .1706 Residential Operations	I Tx. Child/Adol -	V 298			
	of 12 children and add (b) Family members of persons shall be invol- in order to assure a strestrictive setting. (c) The residential tre- shall coordinate with to to ensure that the child- met as identified in the the treatment plan. Me able to attend school; coordinate services and alternative learning pro- job placement. (d) Psychiatric consul- needed for each child (e) If an adolescent has receiving treatment in for six months or until the year, whichever is long (f) Each child or adole age-appropriate personal entitlement is counter- plan. (g) Each facility shall of	serve no more than a total blescents. For other legally responsible wed in development of plans mooth transition to a less attent staff secure facility he local education agency d's educational needs are exchild's education plan and lost of the children will be for others, the facility will be the same station shall be available as for adolescent. The same station of the state fiscal be seen of the state fiscal station of the state fiscal stati				

Division	of Health Service Regu	lation				MIT I NOVED	
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-776		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			(X3) DATE SURVEY COMPLETED	
						R 3/23/2022	
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V 298	Continued From page	5	V 298				
	This Rule is not met a						
	allowed a client to rem of the maximum allow following clients 18th b	w and interview, the facility nain in the facility in excess ed time of six months pirthday or until end of the ing 1 of 2 clients (client #1).					
	- Date of admission 7/ - Diagnoses- Major De with episodic suicidal in Post-Traumatic Stress otherwise specified; Au	pression, recurrent, severe					
	- Client was under the Department of Social S county prior to 18th bir - Client #1's person cer	Services (DSS) in her home thday; ntered profile (PCP) dated 2's long range outcome is					
	Interview on 2/24/22 wi - She turned 19 in Octo - Planned to live at an i					1	
	#1/Executive Director re - No waiver was comple - "Actively trying to find to go."	eted; her (client #1) somewhere					
	 It's been difficult to find due to behaviors; Client #1 recently had 	d client #1 a placement an interview at an					

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: MHL060-776 B. WING 03/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5601 FAULCONBRIDGE ROAD **NEW PLACE** CHARLOTTE, NC 28227 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 298 Continued From page 6 V 298 independent living facility; - Client #1 "went today for a psychological evaluation." - Client #1 has nowhere to go if she was discharged today. V 367 27G .0604 Incident Reporting Requirements V 367 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: reporting provider contact and (1)identification information; client identification information; (2)(3)type of incident; (4)description of incident; (5)status of the effort to determine the cause of the incident; and other individuals or authorities notified (6)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

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NEW PLACE STREET ADDRESS, CITY, STATE, ZIP CODE CHARLOTTE, NC 28227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR I SC IDENTIFYING INFORMATION) A. BUILDING: COMPLETED R O3/23/20 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SERVING NEW PLACE STREET ADDRESS, CITY, STATE, ZIP CODE SERVING CHARLOTTE, NC 28227 (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 367 Continued From page 7 V 367	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5601 FAULCONBRIDGE ROAD CHARLOTTE, NC 28227 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 7 V 367	22	
NEW PLACE 5601 FAULCONBRIDGE ROAD CHARLOTTE, NC 28227 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 7 V 367		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 7 V 367		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 7 V 367		
V 307	(X5) MPLETE DATE	
day whenever:		
(1) the provider has reason to believe that information provided in the report may be erroneous, milselading 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 provideres 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-776		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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V 367	Continued From page	8	V 367				
	the possession of a c (5) the total nur incidents that occurre (6) a statement been no reportable in incidents have occurr meet any of the criteri	lient; mber of level II and level III d; and indicating that there have cidents whenever no ed during the quarter that a as set forth in Paragraphs e and Subparagraphs (1)					
	failed to ensure incide Local Mangement Enti area where services a of becoming aware of are: Record review on 2/25 revealed: - Date of admission 7/6 - Diagnoses- Major De with episodic suicidal id Post-Traumatic Stress otherwise specified; Au	w and interview, the facility of the ward interview, the facility of the ward reported to the sty(LME) for the catchment of provided within 72 hours the incident. The findings with a facility of client #1's record for the facility of client #1's record					
1		RIS) 2/28/22 and 3/21/22					

Division	of Health Service Regu	lation			1011	MATTIOVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
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V 367	Continued From page	9	V 367			
	- "Staff left me and I w - "I left the home(facili - "I went to staff's hom - "Staff threaten to hit - Police called to the h - Went to local hospita - Denied property dam Interview on 2/24/22 w - Client #1 wanted to le leave with staff; - Client #1 found a ride - Staff's husband didn' - Client #1 found a way - Client #1 caused prohome; - Police were called to - Client #1 went to the - Client #1 wants to live	ty)."; ne."; me in the head."; nome; nl; nage to staff's home. vith client #2 revealed: eave with staff but unable to e to staff's house; t let her in their home; y into staff's home; perty damage in the staff's the home; hospital;				
	property on yesterday (- Client #1 attempted to well; - Client #1 ran away an - Client #1 got into the sigarage; - Client #1 destroyed the - Police were called; - Client #1 stated that sherself;	#1/Executive director strained due to destroying (2/24/22); assault an employee as d went to the staff's home; staff's home through the e property at staff's home; he was going to harm een to the hospital by the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-776		1, , , , , , , , , , , , , , , , , , ,		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED R 03/23/2022	
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V 367	Continued From page	10	V 367					
	- Client #1 was discha morning (2/25/22); - Forgot to put inciden	arged from hospital the next						
V 736	27G .0303(c) Facility a	and Grounds Maintenance	V 736					
	10A NCAC 27G .0303 EXTERIOR REQUIRE (c) Each facility and its maintained in a safe, of manner and shall be k odor.	MENTS s grounds shall be clean, attractive and orderly						
	This Rule is not met a Based on observations failed to be maintained and orderly manner. Th	and interviews, the facility a safe, clean, attractive						
	and dented; - Bathroom in hallway h 5 inches long in the doo - Light switch fixture wa room; - Broken sink with triang missing from sink in the the last bedroom on the	billowing: ut the facility were rusted has a crack approximately or; as missing in client #2's gle shape piece of tile a bathroom connected to e left; aint spots on the floor in				8		
1	nterview on 2/25/22 an Qualified Professional # evealed:	d 3/23/22 with the						

STATE FORM

	of Health Service Regu				. 011	MITAL TROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-776			E CONSTRUCTION	(X3) DATE COMP	(X3) DATE SURVEY COMPLETED	
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V 736	Continued From page	± 11	V 736			
	- Vents are old and ur replace; - Made some improve - Plan to start on the n	ements to the home already;				
		tutes a re-cited deficiency				
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STATE FORM

APR 27 2022

New Place MHL-060-776

Plan of Correction for Complaint Survey completed 03/23/2022 Cert. Section

V118 27G.0209 (C) Medication Requirements 10A NCAC 27G .0209 Medication requirements

This Rule is not met as evidenced by: Based on record review, observations and interviews, the facility failed to ensure a MAR of medications administered to each client was kept current and medications were administered as ordered affecting 1 of 2 clients (client #2).

Executive Director James Hunt scheduled a refresher course in medication administration for April 26, 2022, to include all residential counselors and house managers. The House Managers will complete weekly check to determine accuracy of the MAR's and report any deficiency to the Executive Director immediately for corrections. The Executive Director will be responsible for monitoring the MAR's and medications monthly to assure the medication supply is efficient and that there are adequate refills. The monitoring of this will be ongoing and reviewed on a quarterly basis by the Quality Assurance/ Quality Improvement Committee.

V131 G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY

This Rule is not met as evidenced by: V 131 Based on record review and interview, the facility failed to access the Health Care Personnel Registry (HCPR) prior to offer of employment affecting 1 of 5 staff (staff #2).

As of 04/01/2022 Executive Director James Hunt has taken on the responsibility of managing employee records to include hiring process, background checks, HealthCare Personnel Registry Checks, and scheduling of all mandatory trainings. All criminal background checks and Health Care Personnel Registry checks will be completed to hiring, with all mandated trainings being completed within 30 days of hiring. The monitoring of this will be ongoing and reviewed on a quarterly basis by the Quality Assurance/Quality Improvement Committee.

V128 27G .1706 Residential Tx. Child/Adol – Operations

This Rule is not met as evidenced by: Based on record review and interview, the facility allowed a client to remain in the facility in excess of the maximum allowed time of six months following client's 18th birthday or until end of the state fiscal year affecting 1 of 2 clients (client #1).

New Place, Inc. will implement G.S. 27G.1706 by appropriately linking and discharging all consumers prior to their 18th birthday and no later than six months after their 18th birthday or the end of the State fiscal year, whichever is first. The monitoring of this will be ongoing and reviewed on a quarterly basis by the Quality Assurance/ Quality Improvement Committee.

V367 27G .0604 Incident Reporting Requirements

This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure incidents were reported to the Local Management Entity (LME) for the catchment area where services are provided within 72 hours of becoming aware of the incident.

Executive Director James Hunt has scheduled a mandatory incident report training on 04/26/2022 to review the incident reporting process of completing all incident report within 24 hours of the incident and providing that incident report to the Executive Director and the entry of the incident report will be within the 72 hours of the incident. The monitoring of this will be ongoing and reviewed on a quarterly basis by the Quality Assurance/ Quality Improvement Committee.

 $V736 \quad 27G.0303(c) \ Facility \ and \ Grounds \ Maintenance \ 10A \ NCAC \ 27G.0303 \ LOCATION \ AND \ EXTERIOR \ REQUIREMENTS$

This Rule is not met as evidenced by: V 736 Based on observations and interviews, the facility failed to be maintained a safe, clean, attractive, and orderly manner. The findings are:

Executive Director James hunt has contacted a contractor to make all necessary and cited repairs to the facility and they will have all repairs completed no later than May 08, 2022. A receipt will be provided upon completion of the work. The facility house manager will be responsible for conducting weekly house inspections and to report any damage to the Executive Director within 24 hours of identifying any damage or needed repairs. The Executive Director will be responsible for scheduling and the completion of required repairs within three business days. The monitoring of this will be ongoing and reviewed on a quarterly basis by the Quality Assurance/ Quality Improvement Committee.