	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL047-131		B. WING		09/2	26/2022
NAME OF I	PROVIDER OR SUPPLIER	STF	REET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HOPE G	ARDENS TREATMEN	T CENTER		NPIKE ROA	=		
		RA	EFORE	), NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  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 000	INITIAL COMMENT	rs		V 000			
	This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents.  This facility is licensed for 12 and currently has a census of 11. The survey sample consisted of audits of 5 current clients.						
V 110	27G .0204 Training Paraprofessionals	/Supervision		V 110			
	SUPERVISION OF (a) There shall be a paraprofessionals.	204 COMPETENCIES AN PARAPROFESSIONAL no privileging requiremen	S nts for				
	associate professio professional as spe Subchapter.	als shall be supervised be onal or by a qualified ecified in Rule .0104 of the	-				
	knowledge, skills ar population served.	als shall demonstrate nd abilities required by th	ie				
	employment system then qualified profe	s a competency-based n is established by rulem ssionals and associate					
	(e) Competence sh exhibiting core skills		e.				
	<ul><li>(1) technical knowl</li><li>(2) cultural awaren</li></ul>						
	(3) analytical skills;	· ;					
	<ul><li>(4) decision-makin</li><li>(5) interpersonal sl</li></ul>						

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
				231251110.			C
		MHL047	-131	B. WING			26/2022
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HOPE G	ARDENS TREATMEN	T CENTER		NPIKE ROA D, NC 28376			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 110	Continued From pa  (6) communication (7) clinical skills. (f) The governing to develop and impler for the initiation of to plan upon hiring ear	skills; and body for each f nent policies a he individualize	nd procedures ed supervision	V 110			
	This Rule is not me Based on record re four staff (the Vice to demonstrate the required for the pop are:	view and inter President of O knowledge, sk	views one of perations) failed kills and abilities				
	Cross Reference: 131E-256 Health Care Personnel Registry (V132). Based on record review and interview, the facility failed to ensure an allegation of abuse was reported to Health Care Personnel Registry (HCPR) within five working days.  Cross Reference: 10A NCAC 27G .0603 Incident Response Requirements for Category A and B Providers (V366). Based on record review and interviews, the facility failed to implement a policy governing their response to Level III incidents as required.						
	Cross Reference: 1 Reporting Requirer Providers (V367). E interviews, the facil were reported to the Entity/Managed Ca	nents for Cate Based on recor ity failed to ens e Local Manag	gory A and B od review and sure incidents gement				

Division of Health Service Regulation

STATE FORM 6899 ME0U11 If continuation sheet 2 of 24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		MHL047-	131	B. WING			C 2 <b>6/2022</b>
NAME OF I	PROVIDER OR SUPPLIER			DRESS, CITY, S	STATE, ZIP CODE		
HOPE G	ARDENS TREATMEN	CENTER		NPIKE ROA D, NC 28376			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		IENCIES DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 110	Continued From pa	ge 2		V 110			
	for the catchment a provided within 72 h the incident.						
V 132	G.S. 131E-256(G) I Allegations, & Prote		ion,	V 132			
	G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY  (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes:  a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.  b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.  c. Misappropriation of the property of a healthcare facility.						
	d. Diversion of dru facility or to a patier e. Fraud against a a patient or client for providing services). Facilities must hav acts are investigate to protect residents investigation is in pro- investigations must Department within for notification to the D	nt or client. health care factor whom the em e evidence that d and must ma from harm whi rogress. The re be reported to ive working day	cility or against aployee is all alleged ke every effort le the sults of all the				

Division of Health Service Regulation

STATE FORM 6899 ME0U11 If continuation sheet 3 of 24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
				7. BOILDING.			С
		MHL047-	131	B. WING			26/2022
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HOPE G	ARDENS TREATMEN	IT CENTER		RNPIKE ROA D, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFIC Y MUST BE PRECEI LSC IDENTIFYING IN	DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	(X5) COMPLETE DATE	
V 132	<b>F</b>		d bug	V 132			
	This Rule is not meased on record refailed to ensure an reported to Health (HCPR) within five are:  Review on 9/14/22-Admission date of Diagnoses of Pos Intermittent Explose Hyperactivity Disord Dysregulation Discenses and a history of an swings, homicidal causing harm to ot Review on 9/14/22 dated 8/28/22 reversible and a history of an swings, homicidal causing harm to ot Review on 9/14/22 dated 8/28/22 reversible and the same standard the same standard and staff #4] assaulted 8/27/22. The client the incident all agree and record to the same standard the same sta	of client #1's reference of a In-house is reported to multipat a staff members of that were willing that were willing that were willing that the control of the client #1's in the control of the client #1's that were willing the client #1's reference of client #1'	view, the facility buse was al Registry The findings ecord revealed: ess Disorder, ttention Deficit tive Mood efollowing-Heerratic mood ing fights and encident report to le staff er, [Former e evening of ng to talk about				

Division of Health Service Regulation

STATE FORM 6899 ME0U11 If continuation sheet 4 of 24

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV				
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED			
	MHL047-131	B. WING		09/2	6/2022		
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
HOPE GARDENS TREATMENT	CENTER	NPIKE ROA D, NC 28376					
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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		
work in a bad mood not to provoke him of used profanity and the physical consequent [FS #4] stated that it and [client #1] ran of they only saw [FS #4] heard loud banging screaming in pain. It and swearing and heard swearing and heard from graph from they heard from from from from from from from from	.[FS #4] reportedly came to and had warned the clients on this particular day[FS #4] threatened the client with ce. According to witnesses, t was [client #1's] last warning ut of his room again and then 4] enter [client #1's] room and noises. They heard [client #1] They heard [client #1] yelling eard [FS #4] use profanity [client #1]. They heard [client g to bite [FS #4] and then e dared [client #1] to. Next, scream and then some of the 1] on the floor of his room and g over [client #1] with his clients all stated that [staff #1] an to the incident and were d physically remove [FS #4] hysically pulling on [FS #4] hysically pulling on [FS #4] ng like C' mon (come on) e kid[Client #1] has a fresh collar bone about an inch	V 132					

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STATE FORM 6899 ME0U11 If continuation sheet 5 of 24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL047-131	B. WING		C <b>09/26/2022</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
HOPE G	ARDENS TREATMEN	CENTER	RNPIKE ROA D, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 132	press submit and the reported to HCPR to She confirmed the allegation of abuse days.  This deficiency is confirmed the allegation of abuse days.  This deficiency is confirmed to Supervision of Paraprofession of the report	ressed save and forgot to nerefore that incident was not	V 132			
V 366	10A NCAC 27G .06 RESPONSE REQUICATEGORY A AND (a) Category A and implement written presponse to level I, shall require the profession of individuals involved (2) determining of individuals involved (3) developing timeframes according timeframes not to equal to prevent similar in specified timeframes (5) assigning for implementation preventive measures (6) adhering the set forth in G.S. 75,	IREMENTS FOR B PROVIDERS B providers shall develop and colicies governing their II or III incidents. The policies ovider to respond by: to the health and safety needs ed in the incident; ng the cause of the incident; g and implementing corrective g to provider specified xceed 45 days; g and implementing measures acidents according to provider as not to exceed 45 days; person(s) to be responsible of the corrections and				

Division of Health Service Regulation

STATE FORM 6899 ME0U11 If continuation sheet 6 of 24

MHL047-131  MHL047-131  MHL047-131  STREET ADDRESS, CITY, STATE, ZIP CODE  1958 TURRPIKE ROAD  RAFORD, NC 28376  PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1958 TURRPIKE ROAD  RAFORD, NC 28376  PROVIDER'S PLAN OF CORRECTION  (EACH DEFICIENCY)  PREFIX  TAG  COMPLETE  (EACH DEFICIENCY MUST BE RECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  V 366  Continued From page 6  (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, CLEF/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; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team shall consist of individuals who were not involved in the incident. The internal review team shall consist of individuals who were not responsible for the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ,	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  HOPE GARDENS TREATMENT CENTER  1958 TURNPIKE ROAD RAEFORD, NC 28376  (X4) ID (X4				A. BUILDING	:			
C(A) ID   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   PRETIX TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   PRETIX TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   PRETIX TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   PRETIX TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   CROSS-REFERENCE TO THE APPROPRIATE DATE   DEFICIENCY)    V 366   Continued From page 6			MHL047-131	B. WING			_	
(XA)   D   SUMMARY STATEMENT OF DEFICIENCIES   PROVIDER'S PLAN OF CORRECTION (AS)	NAME OF I	PROVIDER OR SUPPLIER	STREE	ADDRESS, CITY,	STATE, ZIP CODE			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 366  Continued From page 6  (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:  (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as	HOPE G	ARDENS TREATMEN	TCENTER					
(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by:  (1) immediately securing the client record by:  (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team shall consist of individuals who were not involved in 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 consist of individuals who were and the time of the incident. The internal review team shall consist of individuals who were most professional oversight of the client's services at the time of the incident. The internal review team shall consist of individuals who	PRÉFIX	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TION SHOULD BE THE APPROPRIATE	COMPLETE	
(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	V 366	(7) maintaining Subparagraphs (a) (b) In addition to the Paragraph (a) of this shall address incide regulations in 42 CI (c) In addition to the Paragraph (a) of this providers, excluding develop and implementation their response to a while the provider is or while the client is The policies shall response to a while the client is The policies shall response to a while the client is The policies shall response to a while the client is The policies shall response to a while the client is The policies shall response to a while the client is The policies shall response to a while the client is the policies shall response to a while the client is the policies shall response to a while the provider is making a (C) certifying (D) transferring review team within internal review team within internal review team within internal review team within internal review team shall confollows:  (A) review the determine the facts and make recommon occurrence of future (B) gather otto is sue writh within five working of the paragraph (a) of th	ng documentation regarding (1) through (a)(6) of this Rul ne requirements set forth in is Rule, ICF/MR providers ents as required by the fede FR Part 483 Subpart I. In requirements set forth in is Rule, Category A and B is Rule, Category B is R	e. ral ng nd d d or				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		C	
		MHL047-131	B. WING			, 6/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HOPE G	ARDENS TREATMEN	T CENTER	NPIKE ROA D, NC 28376			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	)N	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	COMPLETE DATE
V 366	Continued From pa	ige 7	V 366			
	LME in whose catch located and to the Lif different; and (D) issue a fir owner within three final report shall be catchment area the LME where the clie final written report sidentified by the intrinclude all public do incident, and shall reminimizing the occur all documents need available within three LME may give the partner where the services and the LME rearea where the services (A) immediate (A) the LME rearea where the services (B) the LME rearea where the services (C) the provice for maintaining and treatment plan, if diprovider; (D) the Depart (E) the client applicable; and	hment area the provider is _ME where the client resides, and written report signed by the months of the incident. The sent to the LME in whose provider is located and to the art resides, if different. The shall address the issues ernal review team, shall ocuments pertinent to the make recommendations for arrence of future incidents. If ded for the report are not be months of the incident, the provider an extension of up to both the final report; and ely notifying the following: esponsible for the catchment vices are provided pursuant to where the client resides, if the der agency with responsibility and updating the client's efferent from the reporting				
	This Rule is not me Based on record re	et as evidenced by: view and interviews, the				

6899

Division of Health Service Regulation STATE FORM

ME0U11 If continuation sheet 8 of 24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		MHL047-	131	B. WING			C <b>26/2022</b>
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		r oflitted		NPIKE ROAI			
HOPE G	ARDENS TREATMEN	CENTER	RAEFORI	D, NC 28376			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 366	Continued From pa	ge 8		V 366			
	facility failed to impless response to Level I findings are:	ement a policy Il incidents as r	equired. The				
	Review on 9/14/22 -Admission date of -Diagnoses of Post Intermittent Explosi Hyperactivity Disord Dysregulation Disord -He was 12 years of -Assessment dated had a history of and swings, homicidal the causing harm to oth	3/9/22. Traumatic Streve Disorder, At der and Disrupt der. Id. 3/9/22 had the ger outbursts, enreats, instigati	ess Disorder, tention Deficit ive Mood e following-He rratic mood				
	Review on 9/14/22 dated 8/28/22 reveated 8/28/22 reveated lients represented as staff #4] assaulted 8/27/22. The clients the incident all agreated incident all agreated incident all agreated profanity and physical consequer [FS #4] stated that and [client #1] rand they only saw [FS # heard loud banging screaming in pain. and swearing and hand threats back to #1] say he was goin heard [FS #4] say he they heard [FS #4] say he they heard [FS #4] say he was goin heard [FS #4] say he wa	aled: borted to multip t a staff member [client #1] in the sthat were willing ed that [client # .[FS #4] reported and had warned on this particula threatened the face. According threaten	ole staff er, [Former e evening of ng to talk about #1] provoked edly came to ed the clients ar day[FS #4] client with to witnesses, 's] last warning again and then #1's] room and neard [client #1] ent #1] yelling se profanity ey heard [client 4] and then #1] to. Next, en some of the of his room and				

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STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL047-131	B. WING		C <b>09/26/2022</b>	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	09/2	.0/2022
		1958 TUF	RNPIKE ROA	,		
HOPE G	ARDENS TREATMEN	T CENTER RAEFOR	D, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 366	and [staff #2] both recovered to trying to verbally and from [client #1] by pand saying something [client #1] only a little scratch on his right long."  Review of the Incides System (IRIS) on 900.  There was no docure port completed by Operations or other above issue.  There was no docure above issue.  There was no docure according to the proper incidents actime frames not to exceed 45 dasimilar incidents and Interview on 9/15/22 revealed:  The Vice Presiden responsible for ensput into IRIS.  The Nurse or First would normally do to the Vice Presiden information from the IRIS.  He confirmed the fipolicy governing the incidents as required.	clients all stated that [staff #1] ran to the incident and were ad physically remove [FS #4] ohysically pulling on [FS #4] ing like C' mon (come on) le kid[Client #1] has a fresh collar bone about an inch  ent Response Improvement /14/22 revealed: umentation of an incident of r management staff for the umentation to determine: The nt; no corrective measures ovider specified timeframes ays; no measures to prevent cording to provider specified exceed 45 days and assigning ponsible for implementation of a preventive measures.  2 with the Executive Director to of Operations was uring the above incident was  Responder during that shift the In-house incident report. It of Operations would put the at In-house incident report into facility failed to implement a ter response to Level III ed.				
	Operations revealed	2 with the Vice President of d:				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		MHL047-1	31	B. WING		09/2	26/2022
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HOPE G	ARDENS TREATMEN	T CENTER		NPIKE ROA D, NC 28376			
(X4) ID PREFIX TAG		TEMENT OF DEFICI ' MUST BE PRECED SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 366	Continued From pa -She was aware of FS #4She was responsible IRIS. She didn't put anymoreShe thought she put press submit and the reported to IRISShe confirmed the policy governing the incidents as required. This deficiency is concompared to IRIS. This deficiency is concompared to IRISShe confirmed the policy governing the incidents as required. This deficiency is concompared to IRISShe confirmed the policy governing the incidents as required. This deficiency is concompared to IRISShe confirmed the policy governing the incidents as required.	the incident with the incident with ole for putting the incidents into II ressed save and rerefore that incident facility failed to be response to I response to I ross referenced COMPETENCIE	at incident into RIS as often d forgot to ident was not implement a Level III into 10A S AND	V 366			
V 367	27G .0604 Incident Reporting Requirements  10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:		V 367				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						SURVEY PLETED	
		MHL047-1	31	B. WING			C 2 <b>6/2022</b>
NAME OF	PROVIDER OR SUPPLIER			DRESS, CITY, S	STATE, ZIP CODE		
HOPE G	ARDENS TREATMEN	T CENTER		D, NC 28376			
(X4) ID PREFIX TAG		TEMENT OF DEFICIE  MUST BE PRECEDE  SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 367	(1) reporting identification inform (2) client ider (3) type of ind (4) description (5) status of the cause of the incider (6) other indivor responding. (b) Category A and missing or incomples shall submit an updare port recipients by day whenever: (1) the provide erroneous, mislead (2) the provide erroneous, mislead (2) the provide erroneous (2) the provide erroneous (2) the provide erroneous (3) the provide erroneous (4) the provide erroneous (5) the provide erroneous (6) Category A and upon request by the obtained regarding (1) hospital reinformation; (2) reports by	provider contact ation; atification inform cident; n of incident; the effort to detent; and viduals or authorities at the end of the related report to all the end of the related report to all the end of the related report ing or otherwise dent form that we at LME, other information in the incident, increased including other authorities at the end of the report of the incident, increased including of the incident. On the incident of the incident of the incident of the incident. Can a copy of all lead client death to contact the incident. In the incident. In the incident of the incident of the incident of the incident of the incident. In the incident of the incident. In the incident of the incid	ation; ermine the rities notified all explain any The provider Il required next business to believe that hay be to unreliable; or mation vas previously all submit, formation luding: confidential tes; and to the incident. all send a copy Division of abilities and to hours of ategory A vel III the Division of to cases of the of seclusion to the death	V 367			

6899

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPP AND PLAN OF CORRECTION IDENTIFICATION I			` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
				7 50.25 (6.			С
		MHL047	7-131	B. WING			26/2022
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
HOPE G	ARDENS TREATMEN	T CENTER		NPIKE ROAI D, NC 28376			
(X4) ID PREFIX TAG	SUMMARY ST/ (EACH DEFICIENC REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 367	.0300 and 10A NC. (e) Category A and report quarterly to a catchment area who The report shall be by the Secretary vinclude summary in (1) medication of a level (2) restrictive the definition of a level (3) searches (4) seizures the possession of a (5) the total incidents that occur	AC 27E .01046 d B providers sthe LME responsere services as submitted on a electronic material as a conference of the light of the level of a client of level of a client proper a client; and the light of level of a client of level incidents when the light of the level of a client of level and the light of level of a client; and the light of level of le	shall send a possible for the provided. It is a form provided eans and shall follows: do not meet the incident; that do not meet ill incident; this living area; try or property in the incident in el II and level III that there have enever no incident that the in Paragraphs	V 367			
	This Rule is not m Based on record re facility failed to ens the Local Manager Organization (LME where services are becoming aware of Refer to V-366 reg governing their res	eview and intersure incidents on the incidents of the incident of the incident. The incident of the incident o	views, the were reported to maged Care catchment area in 72 hours of The findings are: enting a policy				

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
						C	
		MHL047	131	B. WING		09/2	26/2022
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
HOPE G	ARDENS TREATMEN	CENTER		NPIKE ROAI D, NC 28376			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 367	Continued From pa	ge 13		V 367			
	-There was an alleg #4 and client #1. -Review of the Incic System (IRIS) reve Operations failed to LME/MCO within 72 This deficiency is co NCAC 27G .0204 O SUPERVISION OF PARAPROFESSIO level deficiency and days.	lent Reporting aled the Vice Foreport to the increase references COMPETENCII	Improvement President of incident to the d into 10A ES AND				
V 512	27D .0304 Client R	ights - Harm, A	buse, Neglect	V 512			
	10A NCAC 27D .03 HARM, ABUSE, NE (a) Employees sha abuse, neglect and with G.S. 122C-66. (b) Employees sha sort of abuse or neg 27C .0102 of this C (c) Goods or servic purchased from a c established governi (d) Employees sha necessary to repel aggressive client ar governing body poli is necessary depen characteristics of th and physical and m of aggressiveness of intervention proced Subchapter 10A NC (e) Any violation by (a) through (d) of th	EGLECT OR E Il protect client exploitation in Il not subject a glect, as define hapter. ces shall not be lient except the ng body policy Il use only that or secure a vio nd which is per cy. The degre ds upon the in re client (such ental health) a displayed by th ures shall be c CAC 27E of this van employee	s from harm, accordance client to any ed in 10A NCAC e sold to or rough degree of force lent and mitted by e of force that dividual as age, size and the degree e client. Use of ompliance with a Chapter. of Paragraphs				

Division of Health Service Regulation

STATEMEN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S	
		MIII 047 404			C	
		MHL047-131	b. WING		09/2	6/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HOPE G	ARDENS TREATMEN	T CENTER	NPIKE ROA D, NC 28376			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
V 512	Continued From pa	ige 14	V 512			
	dismissal of the em	ployee.				
	This Rule is not me					
		views and interviews, one of				
		S #4) abused one of five nts (#1) and two of three				
	current audited stat	ff (#1 and #2) neglected one of				
	five current audited	clients (#1). The findings are:				
	Review on 9/14/22 of the facility's personnel records revealed:					
	FS #4:					
	-Date of hire was 6					
	-He was hired as a -He was terminated	Residential Mentor. d on 8/28/22.				
	Staff #1:					
	-Date of hire was 5 -He was hired as a	/8/22. Residential Mentor.				
	Staff #2:					
	-Date of hire was 9	/25/20.				
	-She was hired as a	a Residential Mentor.				
	Review on 9/14/22 -Admission date of	of client #1's record revealed: 3/9/22.				
		traumatic Stress Disorder,				
		ive Disorder, Attention Deficit der and Disruptive Mood				
	Dysregulation Disor					
	-He was 12 years o	old.				
		I 3/9/22 had the following-He ger outbursts, erratic mood				
		hreats, instigating fights and				
	causing harm to oth					
	Review on 9/14/22	of a In-house incident report				

Division of Health Service Regulation

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	IT OF DEFICIENCIES		(V2) MULTIPL	E CONSTRUCTION	(V2) DATE	CLIDV/EV/
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	LETED
			A. BUILDING:			
					C	
		MHL047-131	B. WING		09/2	6/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		1958 TUR	NPIKE ROA	D		
HOPE G	ARDENS TREATMEN	T CENTER	D, NC 28376			
(V4) ID	STIMMADV STA	TEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	)N	(VE)
(X4) ID PREFIX		/ MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				DEFICIENCY)		
V 512	Continued From pa	ge 15	V 512			
	•					
	dated 8/28/22 reveal					
		ported to multiple staff t a staff member, [FS #4]				
		it a stail member, [FS #4] ] in the evening of 8/27/22.				
		re willing to talk about the				
		that [client #1] provoked [FS				
		6 #4] reportedly came to work				
		had warned the clients not to				
		s particular day[FS #4] used				
		ened the client with physical				
	consequence. Acco	ording to witnesses, [FS #4]				
		lient #1's] last warning and				
		f his room again and then they				
		nter [client #1's] room and				
		noises. They heard [client #1]				
		They heard [client #1] yelling				
		neard [FS #4] use profanity				
		[client #1]. They heard [client				
		ng to bite [FS #4] and then				
		ne dared [client #1] to. Next, scream and then some of the				
		21] on the floor of his room and				
		ng over [client #1] with his				
		clients all stated that [staff #1]				
		an to the incident and were				
		d physically remove [FS #4]				
		physically pulling on [FS #4]				
		ing like C' mon (come on)				
	[client #1] only a litt	le kid[Client #1] has a fresh				
		collar bone about an inch				
	long."					
		2 with client #1 revealed:				
		dent with FS #4 just recently.				
		mber the exact date, it was a				
		e incident occurred during 2nd				
		t most of the clients were in				
	their bedroom poss	oe in a bad mood at the				
	pegiriring of his shi	ft. He was in his bedroom and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
				A. BUILDING.			C	
		MHL04	17-131	B. WING			26/2022	
NAME OF PROVIDER OR S	UPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
HOPE GARDENS TRE	ATMEN	T CENTER		NPIKE ROAI D, NC 28376				
PREFIX (EACH DI	EFICIENC'	ATEMENT OF DE Y MUST BE PREC SC IDENTIFYING		ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 512 Continued I	Continued From page 16							
heard FS # because I'n -He told FS that." -FS #4 said -He then we are you out with meHe told FS like that." H bite you." -FS #4 was FS #4 was FS #4 was -He was sta arguing with -FS #4 ther the floor in wallHe was lay bedroom as with one had other handA few seccepushed him -When staff started biting -He saw state thought shed -He did not incidentFS #4 scrapher thought linterview of -He witness and FS #4FS #4 told so don't me	4 say "on not in #4 "you ent to go of your #4 "you et old F standing in FS #4 on agains of #1 pushed his bed on agains of #1 pushed example was jurecall statched his necess with	lon't f*****g methe mood took a don't have to mething about the water and large of the water and large of the doorwal and proom, why a large close to him in the doorwal and him in his command hit was also be a staff #1 grates the wall. The wall was also be a staff #2 interventials neck during that incipate the wall and the wall was also be a water wate	day." To talk to us like  at it you p***y." FS #4 said why re you messing  eep talking to me ry to hurt me, I will  m and he thought  y of his bedroom  chest. He fell onto his head on the  e corner of up by his shirt by neck with the eck. abbed FS #4 and  gainst the wall he  dent, however he ening during that ug that altercation. leeding.	V 512				

Division of Health Service Regulation

STATE FORM 6899 ME0U11 If continuation sheet 17 of 24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		MHL04	7-131	B. WING			C <b>26/2022</b>
NAME OF	PROVIDER OR SUPPLIER			DRESS, CITY, S	STATE, ZIP CODE		0,1011
HOPE G	ARDENS TREATMEN	T CENTER		NPIKE ROA D, NC 28376			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC' REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 512	Continued From parkingryFS #4 and staff #1 back to his bedroor -He then saw FS # bedroom and he feclient #1 hard where -He could hear their -He could hear their -Client #1 told FS # said "I'm going to from the saw FS # he was on the floor #1's neckClient #1 then gral biting him on his least -Staff #1 was trying #4, however he ware -He saw staff #2 go separate client #1 and FS #4When FS #4 arrives aid "I had a bad do -He did not see the loud "thud" in client -He could hear client was in his bed he heard some of -He heard client #1 #4 telling client #1 Interview on 9/14/2 -He witnessed the	kept telling on. 4 push client if Il onto the floor he pushed he m calling each 4 he would bi it k you up." 4 standing ov 5 FS #4 was of bed FS #4's g i to separate of s having a ha o into the bedrand FS #4.  2 with client # he incident wi ed on the unit ay and don't be incident, how if #1's bedroon nt #1 and FS 't understand  2 with client # thing during the home and trying the incident. yelling at FS to shut up.  2 with staff #1	#1 into his or. FS #4 shoved him. In other a "b***h." ite him. FS #4 wer client #1 while choking client leg and started client #1 and FS rd time. It is room and help for his shift he pother me." wever he heard a m. #4 talking, what they were fest revealed: hat incident with hig to fall asleep. #4. He heard FS it revealed:	V 512			

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DIVISION	of Health Service Re	eguiation					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFIC	CATION NUMBER:	A. BUILDING:		COMP	LETED
		MHL04	47 494	B. WING			
		IVITLU	47-131			09/2	6/2022
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	1958 TUE			NPIKE ROA	ח		
HOPE G	HOPE GARDENS TREATMENT CENTER			D, NC 28376			
	0			-			
(X4) ID PREFIX	SUMMARY STA (EACH DEFICIENCY	TEMENT OF DE		ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L			TAG	CROSS-REFERENCED TO THE APPRO		DATE
					DEFICIENCY)		
1/540	0 " 15	40		1/540			
V 512	Continued From pa	ge 18		V 512			
	#4 in August 2022.						
	-Most of the clients	were in thei	r bedrooms during				
	that incident.	Word in the	i bodiooilio ddillig				
	-During that incider	nt client #1 w	as running in and				
	out of his bedroom.		as ranning in and				
	-He and FS #4 told		ston running in				
	and out of his bedro		stop running in				
	-He then heard clie		S #4 exchanging				
	words. They were "						
	could not remembe						
	saying to each other		o words they were				
	-Client #1 was stan		oorway of his				
	bedroom when he						
	-He saw FS #4 pus						
	bedroom.	II Glierit # i ii	THIS DACK THO HIS				
	-FS #4 pushed clier	nt #1 with for	rce hecause client				
	#1 fell onto the floo						
	-FS #4 then went in						
	was still "cussing" a						
	-Client #1 was still I						
	laying in the corner						
	-FS #4 kept saying						
	me, I dare you to bi		r dare you to bite				
	-Client #1 was still of		and somehow hit				
	FS #4's arm.						
	-He was standing ir	n between F	S #4 and client #1				
	He was trying to se						
	-Client #1 then got						
	to bite him.	arouna mon	og and was a jing				
	-Client #1 stopped	and started l	oiting FS #4's lea				
	instead.	<del></del> .	39				
	-He saw FS #4 pull	ina client #1	around the collar				
	of his shirt when he						
	-He didn't know if F						
	neck.	ac on					
	-He called for staff	#2 and she h	nelped him				
	separate client #1 a						
	-FS #4 did leave the		out 15 minutes				
	however he returne						
	-He didn't report that						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		MHL047	-131	B. WING			C <b>26/2022</b>
	PROVIDER OR SUPPLIER  ARDENS TREATMEN	T CENTER	1958 TUR	DRESS, CITY, S INPIKE ROAI D, NC 28376	=		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 512	Continued From particles when it happened.  -He was a newer st should have handled.  Interviews on 9/14/2 revealed:  -She did recall the if #1 in August 2022.  -She didn't witness on the other hallward a crisis.  -During that incider when she went into #1 biting FS #4's leshe intervened by FS #4.  -She left client #1's she had to go backShe couldn't remenshift after that incidents she had to go backShe didn't report the shift after that incidents had to go backShe couldn't remenshift after that incidents had to go backShe didn't report the shift after that incidents had been shift after	aff and wasn't of that incident with Facility on a client with a client was responsent to managember if FS #4 ent.  2 and 9/15/22 full because he called the incident with the facility on a the facility on a there was an incident was an in	with staff #2  S #4 and client  acident. She was who was having  ad for her and she saw client  #1 away from  That because other client.  completed his  management.  sible for ment.  completed his  to interview FS  a failed to return  with the  ch client #1 and  a physical  mis neck.  8/28/22 some of ncident. The	V 512			

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STATEMEN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				<del> </del>	C	
		MHL047-131	B. WING		09/2	6/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HOPE G	ARDENS TREATMEN	T CENTER	NPIKE ROA D, NC 28376			
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	ON.	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 512	Continued From pa	ge 20	V 512			
V 312	night and it involved -"According to som in with a bad attitud -The clients said cli names and it "esca -"Some of the client bumping against th witness the inciden -He contacted staff witnessed most of t FS #4Staff #2 was also i however it was his towards the end of -Staff #1 and staff # with client #1 and F management staffStaff are supposed management imme -Staff #1 was a new know what to do du -He wasn't sure wh incident to manage  Interviews on 9/14// Director of Operatio -He was aware of tl client #1 on 8/27/22 -He was responsibl investigation involvi -Staff #1 witnessed client #1Staff #1 "corrobora about the incident w	d FS #4 and client #1. e of the clients [FS #4] came le." ent #1 started calling FS #4 lated" from there. ts said they heard a lot of e wall", however they did not t. #1 on 8/28/22 because he that incident with client #1 and nvolved in the incident, understanding she intervened the incident. #2 never reported the incident is #4 to him or other d to report incidents to ediately. ver staff and possibly didn't uring that incident. y staff #2 failed to report the ment.  22 and 9/15/22 with the ons revealed: he incident with FS #4 and 2. e for completing the ing FS #4 and client #1. the incident with FS #4 and ated" the details client #1 told	V 312			
	by the Executive Di	of a Plan of Protection written rector dated 9/15/22 revealed: ction will the facility take to				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	MHL047-131					09/2	26/2022
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS CITY S	STATE, ZIP CODE		
				NPIKE ROA	•		
HOPE G	ARDENS TREATMEN	I CENTER	RAEFORI	D, NC 28376			
(X4) ID PREFIX TAG		TEMENT OF DEFICIE MUST BE PRECEDE SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 512	continued From parensure the safety of Staff will be monitor immediate supervise Intel. Immediate Suttone-volume-cadent Staff would receive Detachment immediate from his duties as Fyour plans to make During biweekly supaddressed where staff also would underested where staff also would underestrictive intervention. Client #1's diagnost Stress Disorder, Intellectual Attention Deficit Hy Disruptive Mood Dy #1 was 12 years old 8/27/22 with client #1 were arguing bathe incident started escalated into a phypushing client #1 definited #1 and FS #4 his right collar bone completed his shift #1. Staff #1 and staff #2 client #1 and FS #4 his right collar bone completed his shift #1. Staff #1 and staff #3 client #1 and staff #4 client #4 and staff #4 client #4 and staff #4 client #4 and staff #4 client #1 and staff #4 client #4	f the consumers red more thorouser on what their pervisor will mo ce towards alls additional training liately. [FS #4] where the above pervision these red for go CPI (Crish when it's feasion."  The sincluded: Postermittent Explosion when it's feasion."  The sincluded: Postermittent Explosion peractivity Disor regulation Disor it and FS #4. Find the sale after the with a sale after the incident after the incid	ghly by job duties nitor staff consumers. ng on Rational vas relieved or. Describe happens. matters will be bing training. is Prevention ble to do  ettraumatic sive Disorder, der and order. Client incident on S #4 and client incident on Incident	V 512	DEFICIENCY)		
	additional administr						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		MHL047-	131	B. WING			C <b>26/2022</b>
NAME OF	PROVIDER OR SUPPLIER			DRESS, CITY, S	STATE, ZIP CODE		
		r CENTED		NPIKE ROA	,		
HOPE G	ARDENS TREATMEN	ICENTER	RAEFORI	D, NC 28376			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 512	Continued From pa	ge 22		V 512			
	day will be imposed of compliance beyo						
V 736	27G .0303(c) Facili	ty and Grounds	Maintenance	V 736			
	10A NCAC 27G .03 EXTERIOR REQUI (c) Each facility and maintained in a safe manner and shall b odor.	REMENTS I its grounds sh e, clean, attract	all be ive and orderly				
	This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure facility grounds were maintained in a safe, clean, attractive, orderly manner and kept free from offensive odor. The findings are:						
	Observation on 9/14 revealed: -Common area of fa-Client #1's bedroor paintClient #2's bedroor paint. Door was der-Client #5's bedroor Blinds were broken-Client #7's bedroor paint. Door had writ paint. Ceiling had b-Bathroom #1-Paint Door was rustedBathroom #2-Crac had dirt like stains of was rusted.	acility-Walls had m-Doorframe had. Paint on walls m-Knob to door. Paint on walls m-Doorframe had ing on it. Walls lack markings. It peeling and fa	d peeling paint. ad peeling ad peeling valls was faded. was missing. was faded. ad peeling had peeling ded on walls. wer. Ceiling				

Division of Health Service Regulation STATE FORM

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DIVISION	of Health Service Re	egulation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
						,
		MIII 047 404	B. WING		00/0	
		MHL047-131	B. WING		09/2	6/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
			RNPIKE ROA			
HOPE G	ARDENS TREATMEN	TCENTER				
		RAEFOR	D, NC 28376			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
TAG	NEGOLATORT OR E	.SO IDENTIFICATION ON MATION)	TAG	DEFICIENCY)	TIMAL	57.11.2
				,		
V 736	Continued From pa	age 23	V 736			
	·					
		m-Writing on the door.				
		sted. Ceiling vent cover was				
	missing. Paint on w					
	-Client #6's bedroor	m-Paint on walls was faded.				
	Blinds were broken	<del>-</del> -				
	-Client #8's bedroom	m-Paint on walls was faded.				
	Plexiglass window l	had a plum sized hole. Ceiling				
	vent cover was mis	ssing.				
	-Client #9's bedrooi	m-Paint on walls was faded.				
	Blinds were broken	1.				
	-Bathroom #3-Stror	ng urine smell. Grayish				
		eiling. Paint on walls was faded				
		eiling vent cover was missing.				
	. ,	sted. Walls were stained.				
		om-Doorframe was rusted.				
	Walls had peeling p					
		om-Knob to door was missing.				
		sted. Writing on the door.				
		was missing. Blinds were				
	broken.					
		o				
		2 with the Executive Director				
	revealed:					
		the maintenance issues with				
	the facility.					
		ers for some of those				
		s. They were still waiting to				
	have the repairs co	mpleted for the facility.				
		facility failed to ensure facility				
	grounds were main	itained in a safe, clean,				
	attractive, orderly m	nanner and kept free offensive				
	odor.	-				
	This deficiency con	stitutes a re-cited deficiency				
	and must be correct					
		,				

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