STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-162	A. BUILDING: _____ B. WING _____	R 10/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL GOD'S CHILDREN OF BURLINGTON	101 RUBY LANE HAW RIVER, NC 27258

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on October 11, 2022. The complaint was substantiated (intake #NC00193461). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents This facility is licensed for 4 and currently has a census of 4. The survey sample consisted of audits of 2 current clients and 2 former clients.	V 000		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure fire and disaster drills were done quarterly on each shift. The findings are:	V 114		

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V 114	Continued From page 1 Review on 10/6/22 of the facility's fire drill log revealed: -There was no 1st shift drill conducted for the 2nd quarter of 2022. Review on 10/6/22 of the facility's disaster drill log revealed: -There were no 1st or 3rd shift drills conducted for the 2nd quarter of 2022. -There were no 1st or 3rd shift drills conducted for the 3rd quarter of 2022. Interview on 10/6/22 with client #1 revealed: -Staff did fire drills with them. -She was not sure how often the fire drills were conducted. -Staff never did disaster drills with them. Interview on 10/6/22 with the Director/Licensee revealed: -The facility had three separate shifts. -She didn't realize staff were not conducting the fire and disaster drills as required. -She confirmed staff failed to ensure fire and disaster drills were done quarterly on each shift.	V 114		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.	V 118		

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V 118	Continued From page 2 (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; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to keep the MAR current affecting one of two audited current clients (#1) and one of two former clients (FC #6). The findings are: a. Review on 10/6/22 of client #1's record revealed: -Admission date of 5/9/22. -Diagnoses of Reactive Attachment Disorder, Generalized Anxiety Disorder, Attention Deficit Hyperactivity Disorder and Disruptive Mood	V 118		

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V 118	Continued From page 3 Dysregulation Disorder. -She was 11 years old. Observation on 10/7/22 at approximately 10:25 am of the medication area revealed: -There was no Montelukast 10 milligrams (mg) (Allergies) available for client #1. Review on 10/6/22 of MAR's for client #1 revealed: -October 2022-Montelukast 10 mg was listed. There were staff initials to indicate the medication was administered 10/3 thru 10/6. Interviews on 10/11/22 with staff #1 and the Qualified Professional revealed: -They were not sure why the Montelukast medication was still listed on the MAR for client #1. -They didn't recall client #1 ever having that medication at the facility and/or taking that medication. -They were not sure why staff was documenting the Montelukast medication was given on the October 2022 MAR. b. Review on 10/6/22 of FC #6's record revealed: -Admission date of 9/9/21. -Diagnoses of Adjustment Disorder with mixed anxiety and depressed mood, Impulse Control Disorder, Conduct Disorder, Post Traumatic Stress Disorder and Disruptive Mood Dysregulation Disorder. -She was 14 years old. -Discharge date of 6/12/22. Review on 10/7/22 of physician's orders for FC #6 revealed: -Order dated 8/6/21 for Melatonin 5 mg (Sleep), one tablet at bedtime.	V 118		

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V 118	Continued From page 4 Review on 10/6/22 of MAR's for FC #6 revealed: April 2022-No staff initials as administered on 4/27 and 4/28 for Melatonin 5 mg. Interviews on 10/7/22 and 10/11/22 with the Director/Licensee revealed: -There were no issues with clients getting their prescribed medications. -She thought staff forgot to sign off on the April 2022 MAR for FC #6. -She confirmed staff failed to keep the MAR current for client #1 and FC #6. Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and	V 296		

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

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V 296	Continued From page 6 and one of two former clients (FC #5). The findings are: Review of facility records on 10/6/22 revealed: -The group home was licensed as a 1700 Residential Treatment Staff Secure for Children or Adolescents. The license capacity was for four children or adolescents. a. Review on 10/6/22 of client #1's record revealed: -Admission date of 5/9/22. -Diagnoses of Reactive Attachment Disorder, Generalized Anxiety Disorder, Attention Deficit Hyperactivity Disorder and Disruptive Mood Dysregulation Disorder. -She was 11 years old. -There was no documentation that client #1 could be supervised by one staff. b. Review on 10/6/22 of client #2's record revealed: -Admission date of 5/13/22. -Diagnosis of Disruptive Mood Dysregulation Disorder. -She was 14 years old. -There was no documentation that client #2 could be supervised by one staff. c. Review on 10/6/22 of FC #5's record revealed: -Admission date of 9/2/22 -Diagnoses of Major Depressive Disorder, Anxiety Disorder, Impulse Control Disorder, Conduct Disorder, Borderline Personality Disorder and Cannabis Abuse Disorder. -She was 17 years old. -She was discharged on 9/4/22. -There was no documentation that FC #5 could be supervised by one staff.	V 296		

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V 296	Continued From page 7 Review on 10/6/22 of a police report dated 9/4/22 revealed: -"On 9/4/22 at 9:10 am [Name of Police Officer] responded to All Gods Children at 101 Ruby Lane for [FC #5]. [Former Staff #7] told me juvenile ran away sometime between 11:00 pm and 7:40 am... One of the other juveniles at the facility made the comment to me that [FC #5] left with her boyfriend...[FS #7] noticed [FC #5] missing at 7:40 am and found an open window she crawled out of and said that she thought she was there at 6:00 am when she arrived at work, but she may have had the bed made up to look like there was a person in it..." Interview on 10/7/22 with former staff #7 (FS #7) revealed: -She was the staff working during the incident with FC #5 when she left the facility on 9/4/22. -She thought she came in that morning at around 6:50 am on 9/4/22. -She talked with staff #2 and #3 for a few minutes. Staff #2 and staff #3 worked the previous shift. -She thought staff #2 and staff #3 left the facility a little after 7:00 am. -She was alone at the facility with those clients when staff #2 and staff #3 left the facility. -She thought it was 3-4 clients at the facility with her. -Staff #4 was supposed to work with her on 9/4/22. She thought staff #4 called the Qualified Professional and said she had an emergency and could not make it to work. -The Qualified Professional told her she was coming to the facility to work with her, however she would be late. -She did check on the clients when she arrived at 7:00 am and they were all in their bedrooms. -She thought she went to the bathroom a little	V 296		

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V 296	Continued From page 8 after 8:00 am. -When she came out of the bathroom client #1 told her FC #5 left the facility. -She called the Qualified Professional and told her about FC #5 left the facility. -She called the police department to report FC #5 left the facility after speaking with the Qualified Professional. -She thought she called the police department around 9:00 am on 9/4/22. -She confirmed the facility failed to ensure minimum staffing requirements were met by direct care staff when children or adolescents are present and awake. Interview on 10/7/22 with the Qualified Professional revealed: -She was aware of the incident with FC #5 leaving the facility on 9/4/22. -On the day of the incident with FC #5, she thought she arrived to the facility a little after 9:00 am. -The shift actually started at 7:00 am. -She was not scheduled to work, however one of the staff called out. She worked with FS #7 during 1st shift on 9/4/22. -FS #7 was alone with the clients until she arrived. -When she was on her way to the facility FS #7 called to report FC #5 left the facility. -She wasn't sure what time FS #7 called to report that incident. She thought it was a few minutes before 9:00 am. -She told FS #7 to call the police department to report FC #5 missing. -She confirmed the facility failed to ensure minimum staffing requirements were met by direct care staff when children or adolescents are present and awake.	V 296		

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V 296	Continued From page 9 Interviews on 10/6/22 and 10/7/22 with the Director/Licensee revealed: -There was an incident on 9/4/22 with FC #5. -FS #7 reported to the Qualified Professional that FC #5 left the facility that morning. -FS #7 was working at the facility alone during 1st shift for a short period of time on 9/4/22. -She wasn't sure how long FS #7 was at the facility alone with those clients. -Staff #4 was scheduled to work 1st shift with FS #7 that day, however she called out. -The Qualified Professional come in and worked with FS #7 instead. -The Qualified Professional did arrive to the facility late on 9/4/22. -She thought FS #7 reported FC #5 missing to the Qualified Professional when she was on her way to the facility. -She confirmed the facility failed to ensure minimum staffing requirements were met by direct care staff when children or adolescents are present and awake.	V 296		
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	V 367		

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V 367	Continued From page 10 Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of	V 367		

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V 367	Continued From page 11 becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure incidents were reported to the Local Management Entity/Managed Care Organization (LME/MCO) for the catchment area where services are provided within 72 hours of	V 367		

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V 367	Continued From page 12	V 367		

becoming aware of the incident. The findings are:

Review on 10/6/22 of Former Client #5's record revealed:
-Admission date of 9/2/22
-Diagnoses of Major Depressive Disorder, Anxiety Disorder, Impulse Control Disorder, Conduct Disorder, Borderline Personality Disorder and Cannabis Abuse Disorder.
-She was 17 years old.
-She was discharged on 9/4/22.

Review on 10/6/22 of a police report dated 9/4/22 revealed:
-"On 9/4/22 at 9:10 am [Name of Police Officer] responded to All Gods Children at 101 Ruby Lane for [FC #5]. [Former Staff #7] told me [FC #5] ran away sometime between 11:00 pm and 7:40 am... One of the other juveniles at the facility made the comment to me that [FC #5] left with her boyfriend...[FS #7] noticed [FC #5] missing at 7:40 am and found an open window she crawled out of and said that she thought she was there at 6:00 am when she arrived at work, but she may have had the bed made up to look like there was a person in it..."

Review on 10/6/22 of the Incident Reporting Improvement System (IRIS) revealed:
-There was no documentation of an incident report completed by group home staff for the above issue.

Interview on 10/7/22 with the Qualified Professional revealed:
-She was aware of the incident with FC #5 leaving the facility on 9/4/22.
-She told FS #7 to call the police department to report FC #5 missing.
-Staff on shift are generally responsible for putting

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V 367	Continued From page 13 the incident into IRIS. -She thought she told FS #7 she would put that incident into IRIS for her. -FS #7 said she didn't feel comfortable putting the incident into IRIS. -She never put the incident into IRIS, she thought she just forgot to do it. -She confirmed the facility failed to ensure a Level II incident report was submitted to the LME within 72 hours as required. Interviews on 10/6/22 and 10/7/22 with the Director/Licensee revealed: -There was an incident on 9/4/22 with FC #5. -FS #7 reported to the Qualified Professional that FC #5 left the facility that morning. -She thought the Qualified Professional did the incident report for the issue with FC #5 leaving the facility. -She confirmed the facility failed to ensure a Level II incident report was submitted to the LME within 72 hours as required.	V 367		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure facility grounds were maintained	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-162	A. BUILDING: _____ B. WING _____	R 10/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL GOD'S CHILDREN OF BURLINGTON	101 RUBY LANE HAW RIVER, NC 27258

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 736	Continued From page 14 in a safe, clean, attractive and orderly manner. The findings are: Observation on 10/6/22 at approximately 1:35 pm revealed: -Client #1 and #4's bedroom-There was a crack in one the window pane approximately two feet long. There was a crack in the other window pane approximately eight inches long. -Upstairs bathroom-Shower door was off hinges and laying against the wall. Shower curtain was sagging. The shower floor was stained and faded. -Upstairs hallway-There was a set of broken blinds. The window had approximately twelve shards of glass encased in window frame and covered by a piece of plexiglass. Interview on 10/6/22 with the Director/Licensee revealed: -She didn't realize the windows were broken in client #1 and #4's bedroom. -The window in the hallway was repaired several months ago. -She wasn't sure why the person who repaired that window left those shards of glass in the window. -She confirmed the facility failed to ensure facility grounds were maintained in a safe, clean, attractive and orderly manner.	V 736		