| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| V 000 | INITIAL COMMENTS<br><br>An annual, complaint and follow up survey was completed on 10/4/22. The complaint was unsubstantiated (intake #NC00193164). Deficiencies were cited.<br><br>This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents.<br><br>This facility is licensed for 96 and currently has a census of 30. The survey sample consisted of audits of 2 current clients and 1 former client. | V 000 | | |
| V 132 | G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection<br><br>G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY<br>(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:<br>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.<br>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.<br>c. Misappropriation of the property of a healthcare facility.<br>d. Diversion of drugs belonging to a health care facility or to a patient or client.<br>e. Fraud against a health care facility or against | V 132 | | |

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| V 132 | Continued From page 1<br>a patient or client for whom the employee is providing services).<br>Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to put measures in place to protect clients during an investigation of an allegation of abuse affecting 1 of 3 audited staff (Staff #1). The findings are:<br><br>Record review on 9/29/22 of Staff #1 ' s personnel file revealed:<br>-Date of hire: 7/27/21<br>-Position/job description: mentor (paraprofessional).<br><br>Review on 9/29/22 of Client #2 ' s record revealed:<br>-Date of admission: 8/11/22<br>-Age 15 | V 132 | | |

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| V 132 | Continued From page 2<br>-Diagnoses of Major Depressive Disorder, recurrent episode, moderate; Generalized Anxiety Disorder and Post-Traumatic Stress Disorder.<br><br>Review on 9/29/22 of student grievance form dated 9/1/22 and without a signature revealed:<br>-"Date, time and place of event leading to grievance: Tuesday 8/29, while we were moving rooms;"<br>-"Details of Occurrence (including names of persons involved, if any): [Staff #1] grabbed me in places and gave me bruises."<br><br>Review on 9/29/22 of facility's internal investigation regarding the anonymous grievance discovered in grievance box on 9/6/22 revealed:<br>-"9/1- date on Grievance form (8/29 was reported to be the day of occurrence on grievance form);"<br>- "9/6- [Client #2] Checked in with Nurses during morning med pass regarding bruising.<br>-PD (Program Director) Director learned of grievance.<br>-Staff involved were switched to working with a different team as soon as we became aware of the grievance;"<br>-Interviews for the investigation were conducted with Client #1, Client #2, Client #3, Staff #1, Staff #3, Staff #4, Lead Mentor #1, Team Manager #2 between 9/6/22 to 9/8/22.<br><br>Review on 10/3/22 of the "Team Discussions and Conclusion Following Investigation" report dated 9/8/22 revealed:<br>-Team members involved in conclusion were the Executive Director, Compliance Officer, Interim Program Director, Director of Human Resources, and Team Manager #1;<br>-"following interviews with staff and students, there is no evidence to support the allegation that staff member [Staff #1] abused or harmed [Client | V 132 | | |

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| V 132 | Continued From page 3<br>#2] ..."<br>-"the team feels confident, at this time, that staff member (Staff #1) is not a risk to the residents safety and well-being at Solstice East."<br>-"He (Staff #1) will continue to work on Eno team, returning to work on Sunday 9/11/22. He has been instructed to maintain a ' rule of three ' , meaning he is not to be alone at any time with students ..."<br><br>Review on 9/30/22 of an email dated 9/6/22 at 4:11pm sent by the Team Manager #1 to Staff #1, the Team Leads, and Team Manager, and the Interim Program Director revealed:<br>-"Please work exclusively on Eno team until further notice. Point staff for room for room 13. In line of sight of another staff at all times. Leads, Please support him (Staff #1) in doing this. This is to support [Staff #1]."<br><br>Review on 9/30/22 of the staff schedule from 8/28/22 to 9/11/22 revealed:<br>-Staff #1 worked second shift on 9/6/22;<br>-Staff #1 did not work on 9/7/22, 9/8/22, 9/9/22, and 9/10/22.<br><br>Review on 9/30/22 of medical progress notes for Client #2 revealed:<br>-9/6/22- [Client #2] came by the nursing office and reported that she had bruises that staff encouraged her to check in with medical about ...RN visualized three round yellow (fading) bruises on her left upper leg ...[Client #2] communicated that she wrote a grievance and told her staff as well as the team manager and interim program director. Email sent to student ' s primary therapist, team manager and interim program director."<br><br>Interview on 9/30/22 with Client #2 revealed: | V 132 | | |

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| V 132 | Continued From page 4<br>-she had "just gotten here" (admitted to the facility) and was on "arms" (arm ' s length from staff);<br>-"at the end of August on a Tuesday, we were all moving rooms" and Staff #1 followed her into her room and grabbed her from behind;<br>-she did not tell anyone at the time of alleged incident between her and Staff #1;<br>-she wrote a grievance two days later and put it in the grievance box; "no one" was checking the grievance box;<br>-she told Staff #4 who suggested she see Nurse #1; when she told Staff #4 "they still didn ' t have the grievance;"<br>-when they found the letter, the therapist "for all the therapists I think" came and spoke to her;<br>-from the time the incident occurred to the time they moved Staff #1, she didn ' t feel safe; Staff #1 was the only staff she was uncomfortable with;<br>-"he (Staff #1) moved to Eno; he was on PTO last week but back on Monday (9/19/22)<br>-sometimes she had to be in the same room with him because "school groups walk together back to the lodge ...little stuff like that;"<br>-Staff #1 has not spoken to her and she has not spoken to him.<br><br>Interview on 9/30/22 with the Nurse #1 revealed:<br>-Client #2 came to the nursing office on 9/6/22 and showed Nurse #1 and Nurse #2 "3 round little bruises resulting from an incident with Staff #1 the previous Tuesday;<br>-Client #2 "didn ' t want to share much ...[Nurse #2] encouraged her to share more to ensure safety;"<br>-she and Nurse #2 notified the team Manager and the Interim Program Director "right away" after Client #2 ' s allegation against Staff #1.<br><br>Interview on 9/30/22 with the Team Manager | V 132 | | |

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| V 132 | Continued From page 5<br><br>#1/Residential Coordinator revealed:<br>-there were 3 teams of students/staff- Alarka, Eno and Laurel;<br>-she was the Team Manager for Laurel as well as the Residential and Training Coordinator;<br>-did the "base schedule ...everyone has the same schedule every week and if here are holes, the team manager is on call and fills the holes that are in that shift ...either find someone or come in, depends on what is needed;"<br>-Staff #1 was working between the Alarka and Eno teams at the end of August 2022;<br>-Staff #4 informed her of the allegation against Staff #1 by Client #2 on the morning of 9/6/22; she "went ahead and made the schedule change in the morning for the evening shift;"<br>-she made the change before receiving the grievance form; once she received the grievance, she took it to the Interim Program Director;<br>-after the advice of the rest of the team (leadership); the plan was for Staff #1 to stay on the Eno team until the investigation was complete;<br>-she didn ' t want to take him off the schedule; didn ' t want to send a "message to a kid that if they make a complaint; they don ' t see the staff;"<br>-Staff #1 was informed he could only be "point" person for a particular room on Eno which meant he was assigned the same room of clients;<br>-she assigned him as the point person for a room near the common rooms he can be seen by the other staff; as point person of that room, he was "always in eyesight of another staff;<br>-as of today (9/30/22) it was still in effect that he was the point person for the same room on Eno;<br>-she sent an email on 9/6/22 to Staff #1 and Team Leads stating that Staff #1 was the point person for that particular room.<br><br>Interview on 9/30/22 with Staff #1 revealed: | V 132 | | |

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| V 132 | Continued From page 6<br>-has worked at the facility for 14 months and worked second shift;<br>-was supervised by Team Manager #2;<br>-heard there was an allegation against him but doesn ' t know what it was;<br>-was working on the Alarka team at the time that Client #2 made the allegation against him;<br>-was switched to the Eno team after Client #2 made the allegation against him;<br>-"they have me working with Eno team right now so I am not anywhere near [Client #2]."<br>-"other than maybe passing through their common area, haven ' t been anywhere near that kid (Client #2).<br><br>Interview on 9/30/22 and 10/3/22 with the Director of Quality Improvement revealed:<br>-Team Manager #1/Training Coordinator made the staff schedule; she moved Staff #1 to a different team when the allegation was made against him;<br>-Client #2 told Staff #4 on 9/5/22 that she filed a grievance;<br>-a client can file a grievance anonymously but through a "collective mind, we can kind of figure out who it is."<br><br>Interview on 9/29/22 with the Director of Human Resources revealed:<br>-there was some confusion about the date of the grievance;<br>-Client #2 wrote that the incident happened on "Tuesday, 8/29/22" but 8/29/22 was a Monday;<br>-with further interviews it was determined that the incident occurred on Monday, 8/29/22;<br>-Client #2 completed the grievance form on 9/1/22.<br><br>Interview on 10/4/22 with the Executive Director revealed: | V 132 | | |

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| V 132 | Continued From page 7<br>-Staff #1 ' s regular work schedule was second shift Sunday to Wednesday;<br>-their policy about suspending staff had been updated since the incident occurred.<br><br>Observation at 3:28pm on 10/3/22 of the facility revealed:<br>-The Alarka team of clients lived on the first floor of the facility;<br>-The Eno and Laurel client teams lived on the second floor of the facility separated by a common room. | V 132 | | |
| V 318 | 13O .0102 HCPR - 24 Hour Reporting<br><br>10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL<br>The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g).<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record review, the facility failed to report allegations of abuse to the North Carolina Health Care Professional Registry | V 318 | | |

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| V 318 | Continued From page 8 | V 318 | | |

(HCPR) within 24 hours of becoming aware of an allegation of abuse against 1 of 3 sampled staff (Staff #1). The findings are:

Refer to V132 for personnel information about Staff #1 and information regarding interviews and allegation by Client #2.

Review on 9/29/22 of student grievance form dated 9/1/22 and without a signature revealed:
-"Date, time and place of event leading to grievance: ' Tuesday 8/29, while we were moving rooms ' ; Details of Occurrence (including names of persons involved, if any): ' [Staff #1] grabbed me in places and gave me bruises ' ..."

Review on 9/29/22 of facility's internal investigation regarding the anonymous grievance discovered in grievance box on 9/6/22 revealed:
-"9/1- date on Grievance form (8/29 was reported to be the day of occurrence on grievance form);"
- "9/6- [Client #2] Checked in with Nurses during morning med pass regarding bruising.
-PD (Program Director) Director learned of grievance.
-Staff involved were switched to working with a different team as soon as we became aware of the grievance;"
-Interviews for the investigation were conducted with Client #1, Client #2, Client #3, Staff #1, Staff #3, Staff #4, Lead Mentor #1, Team Manager #2 between 9/6/22 to 9/8/22.

Review on 9/29/22 of HCPR Initial Allegation Report revealed:
-Facility ' s Director of Human Resources signed and dated form on 9/8/22.
-Incident date: 8/29/22
-Date facility became aware of incident: 9/6/22.

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| V 318 | Continued From page 9<br><br>Interview on 9/30/22 with the Director of Human Resources revealed:<br>-Was not aware allegations needed to be reported within 24 hours. | V 318 | | |
| V 366 | 27G .0603 Incident Response Requirments<br><br>10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS<br>(a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by:<br>(1) attending to the health and safety needs of individuals involved in the incident;<br>(2) determining the cause of the incident;<br>(3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;<br>(4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;<br>(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;<br>(6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and<br>(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.<br>(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.<br>(c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B | V 366 | | |

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| V 366 | Continued From page 10 | V 366 | | |

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 within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:
(A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;
(B) gather other information needed;
(C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and
(D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The

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| V 366 | Continued From page 11<br>final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and<br>(3) immediately notifying the following:<br>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;<br>(B) the LME where the client resides, if different;<br>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;<br>(D) the Department;<br>(E) the client's legal guardian, as applicable; and<br>(F) any other authorities required by law.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to immediately notify other authorities required by law regarding allegations of abuse affecting 1 of 3 audited staff (Staff #1). The findings are:<br><br>Refer to V132 for personnel information about Staff #1 and additional information regarding interviews and allegation by Client #2. | V 366 | | |

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| SOLSTICE EAST, LLC | 530 UPPER FLAT CREEK ROAD WEAVERVILLE, NC 28787 |

| (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 |
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| V 366 | Continued From page 12<br><br>Review on 10/3/22 of the facility ' s Abuse Reporting Policy revealed:<br>-the policy documents that allegations of abuse must be reported to the (local county) Department of Social Services;<br>-the policy did not specify a time frame for how soon the report needed to be made after the facility became of aware of the abuse allegations.<br><br>Interview on with the Department of Social Services (DSS) worker assigned to investigate the allegation revealed:<br>-she initiated her investigation and was at the facility on 9/9/22;<br>-Client #2 told her that she put an anonymous note in the grievance box it wasn ' t found for a few days;<br>-she was informed Staff #1 was moved to another team which occurred before she got involved;<br>-the DSS case was still open and the investigation was ongoing.<br><br>Interview on 9/30/22 with the Team Manager #1/Residential Coordinator revealed:<br>-Staff #4 informed her of the allegation against Staff #1 by Client #2 on the morning of 9/6/22.<br><br>Interview on 10/4/22 with the Executive Director revealed:<br>-The Human Resources director reported the allegation to DSS on 9/8/22.<br>-No documentation that a previous report had been made to DSS prior to 9/8/22. | V 366 | | |