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V 000	INITIAL COMMENTS An annual, complaint, and follow up survey was completed on April 13, 2023. One complaint was substantiated (intake #NC00200664) and one complaint was unsubstantiated (#NC00196378). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1800 Intensive 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 7 current clients. A sister facility is identified in this report. The sister facility will be identified as sister facility A. Sister facility A was newly licensed and had not received any admissions.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons;	V 105	DHSR - Mental Health MAY 16 2023 Lic. & Cert. Section	

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V 105	Continued From page 1 (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted	V 105		

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V 105	Continued From page 2 methods, and the degree of knowledge, skill and care exercised by other practitioners in the field; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to follow the facility's admission assessment policy. The findings are: Review on 4/5/23 of client #1's record revealed: -9 year old male admitted to the facility on 3/20/23. -Diagnoses included Attention Deficit Hyperactivity Disorder (ADHD), combined type; Oppositional Defiant Disorder (ODD); Autism Spectrum Disorder; and Intellectual Disability. -No admission assessment documented. Review on 4/5/23 of client #2's record revealed: -17 year old male admitted to the facility on 3/20/23. -Diagnoses included ADHD, Conduct Disorder, and Post Traumatic Stress Disorder (PTSD). -No admission assessment documented. Review on 4/4/23 of client #6's record revealed: -17 year old male admitted to the facility on 2/21/23. -Diagnoses included ADHD and Borderline Intellectual Functioning. -No admission assessment documented.	V 105	V105 The QP or designee will make all admission assessments completed before admission date. This will be monitored as needed.	May 4, 2023

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V 105	Continued From page 3 Review on 4/4/23 of client #7's record revealed: -14 year old male admitted to the facility on 2/22/23. -Diagnoses included ADHD and Generalized Anxiety Disorder (GAD). -No admission assessment documented. Review on 4/5/23 of client #9's record revealed: -10 year old male admitted to the facility on 3/30/23. -Diagnoses included ADHD and ODD. -No admission assessment documented. Review on 4/4/23 of client #10's record revealed: -17 year old male admitted to the facility on 4/2/23. -Diagnoses included Conduct Disorder, Disruptive Mood Dysregulation Disorder (DMDD), and Major Depressive Disorder. -No admission assessment documented. Review on 4/12/23 of client #11's record revealed: -11 year old male admitted to the facility on 4/5/23. -Diagnoses included ODD, moderate; DMDD, ADHD and Tobacco Use Disorder-severe. -No admission assessment documented. Interview on 4/12/23 the Lead Qualified Professional (QP) stated: -The admission assessments were done by the Lead QP. -If the Lead QP is not able to complete the admission assessment, the Lead QP would delegate the admission assessment to another specific QP on staff. -Since the surveyors were present the prior week and admission assessments were discussed, the Lead QP had made some changes whereby the Lead QP would complete an admission	V 105		

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V 105	Continued From page 4 assessment with input from the guardian. -The new process had not been implemented. -The Lead QP planned to implement the new process to complete admission assessments for the first time on 4/13/23. This deficiency is cross-referenced into 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (Tag V109) for a Standard Deficiency rule violation and must be corrected within 30 days.	V 105		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based	V 109		

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V 109	Continued From page 5 employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record reviews and interviews, 1 of 1 Lead Qualified Professional (QP) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are: Cross Reference: 10A NCAC 27G .0201 GOVERNING BODY POLICIES (V105). Based on record review and interview, the facility failed to follow the facility admission assessment policy Cross Reference: 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (V111). Based on record reviews and interviews, the facility failed to document strategies to address the client's presenting problems when services were provided prior to the implementation of the treatment plan affecting 3 of 7 current clients audited (clients #1, #2, and #10).	V 109	V109 The facility will ensure the lead Qualified Professional (QP) demonstrates the knowledge, skills, and abilities required by the population served. This will be monitored by the Residential Director weekly. 27G. 0201: The facility will ensure the QP follow the facility admission assessment policy. This will be monitored by the Residential Director as needed. 27G. 0205: The facility will ensure to document strategies to address the client's presenting problems when services were provided prior to the implementation of the treatment plan. This will be monitored as needed by QP and Residential Director as needed.	May 4, 2023

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V 109	Continued From page 6 Cross Reference: 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (V521). Based on record reviews and interviews, the facility failed to document the minimum requirements for restrictive interventions in the client's record affecting 6 of 7 audited clients (Clients #1, #2, #6, #7, #9, #10). Cross Reference: 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (V522). Based on record review and interview, the facility failed to obtain orders for restrictive interventions or ensure a responsible professional met with and conducted an assessment of a client following a restrictive intervention affecting 6 of 7 audited clients (Clients #1, #2, #6, #7, #9, #10). Cross Reference: 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (V524). Based on record review and interview, the facility failed to notify the guardian immediately following a restrictive intervention or members of the treatment team affecting 5 of 7 audited clients (Clients #1, #2, #6, #9, #10). Review on 4/6/23 of the Lead Qualified Professional's (QP's) record revealed: -Original hire date: 5/29/19. -Rehire date: 10/31/22. -Met requirements for a QP. Review on 4/6/23 of the Lead QP's job description duties revealed:	V 109	27E. 0104: The facility will ensure to document the minimum requirements for restrictive interventions in all client's record. This will be monitored daily by QP's, Lead QP weekly and Residential Director monthly. 27E. 0104: The facility will ensure to obtain orders for restrictive interventions or members of the treatment team. The QP's and Lead QP will monitor as needed. 27E. 0104: The facility will ensure QP's notify the guardian immediately following a restrictive intervention or members of the treatment. The QP's will monitor as needed. Lead QP will monitor daily.	

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V 109	Continued From page 7 -Conduct monitoring observations to ensure proper implementation of each client's treatment plan. -Initiate and complete any investigations. -Review incident/accident reports. -Report any incidents to the NC IRIS (North Carolina Response Improvement System). -Serve as a liaison between family and residents. Interview on 4/5/23 the Lead QP stated: -She had been rehired by the facility approximately 6 months earlier. -She had been trained on state rules and regulations by the facility Director and through assisting in the application process for state licensure. -She was responsible for completing admission assessments or delegating admission assessments to others. -She was responsible for monitoring incident documentation. Interview on 4/6/23 and 4/13/23 the Director stated: -The Lead QP is responsible for client treatment plans. -Lead QP was responsible to collaborate with the Therapist, Nurse, and Psychiatrist to make sure there were strategies in place to meet the needs of newly admitted clients until a treatment plan could be implemented. -The Lead QP was responsible for incident response and reporting. -There were plans to train other staff to assist the Lead QP with the work load of incident reporting. This deficiency constitutes a recited deficiency and must be corrected within 30 days.	V 109		

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V 111	Continued From page 8	V 111		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.	V 111		

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V 111	Continued From page 9 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to document strategies to address the client's presenting problems when services were provided prior to the implementation of the treatment plan affecting 3 of 7 clients audited (clients #1, #2, and #10). The findings are: Finding #1: Review on 4/5/23 of client #1's record revealed: -9 year old male admitted to the facility on 3/20/23. -Diagnoses included Attention Deficit Hyperactivity Disorder (ADHD), combined type; Oppositional Defiant Disorder (ODD); Autism Spectrum Disorder, and Intellectual Disability. -Person-Centered Plan completed 12/7/22 and updated 3/13/23 by a prior provider documented, "... [client #1] has a history of the following psychiatric symptoms: anxiety, sleep changes, poor hygiene,verbal aggression, non-compliance, self-injurious behaviors, physical aggression, hyperactivity, and poor impulse control." -Client #1 did not have a treatment plan established or implemented by the facility. -There were no strategies documented by the facility to address client #1's presenting problems. Finding #2: Review on 4/5/23 of client #2's record revealed: -17 year old male admitted to the facility on 3/20/23. -Diagnoses included ADHD, Conduct Disorder, and Post Traumatic Stress Disorder (PTSD). -Person-Centered Plan completed 11/18/22 and updated 1/20/23 by a prior provider documented client #2 had disruptive and attention seeking behaviors. Police had responded to his prior respite home due to attention seeking behaviors.	V 111	V111: The facility will ensure to document strategies to address the client's presenting problems when services are provided prior to the implementation of treatment plan. This will be monitored by QP's and Lead QP as needed.	May 4, 2023

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V 111	Continued From page 10 He had 2 hospital evaluations during the prior year after he jumped form a moving vehicle, threatened to harm himself, and then informed the hospital staff he wanted to kill his respite home provider. He intentionally "annoyed" his peers on multiple occasions, and wiped feces on bathroom walls. He had a history of taking things that did not belong to him. In the past year he had made purchases using credit cards he had stolen from his respite home provider and family. The plan update on 1/20/23 documented client #2 was attending a community college to complete his Adult High School Diploma and had "recently" broken into cars at the college and stolen computers and credit cards. -Client #2 did not have a treatment plan established or implemented by the facility. -There were no strategies documented by the facility to address client #2's presenting problems. Finding #3: Review on 4/4/23 of client #10's record revealed: -17 year old male admitted to the facility on 4/2/23. -Diagnoses included Conduct Disorder, Disruptive Mood Dysregulation Disorder (DMDD), and Major Depressive Disorder. -Person-Centered Plan completed 1/10/23 and updated 3/24/23 by a prior provider documented verbal and physical aggressive behaviors toward staff and peers, and threats to elope. -Client #10 did not have a treatment plan established or implemented by the facility. -There were no strategies documented by the facility to address client #10's presenting problems. Interview on 4/12/23 the Lead QP stated: -Child Family Treatment (CFT) Team meetings would be held within 30 days of admission.	V 111		

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V 111	Continued From page 11 -Clients #1, #2, and #10 had not had a CFT meeting. -There were no documented strategies for clients #1, #2, or #10 to address their presenting problems. This deficiency is cross-referenced into 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS(Tag V109) for a Standard Deficiency rule violation and must be corrected within 30 days.	V 111		
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 review and interview the facility failed to have fire and disaster drills held at least quarterly and repeated on each shift. The findings are:	V 114	V114: Fire and Disaster drills will continue to be held quarterly, documented each shift. This will be monitored monthly by Facility Manager, QP's, and Lead QP. The Residential Director will monitor quarterly.	June 3, 2023

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V 114	Continued From page 12 Review on 4/4/23 of facility records from 7/1/22 - 3/31/23 revealed: -1st quarter (7/01/22 - 9/30/22): No disaster drills documented on the 1st and 3rd shifts. -2nd quarter (10/01/22 - 12/31/22): No disaster drills documented on 1st, 2nd, and 3rd shifts. -3rd quarter (1/01/23 - 3/31/23: No fire or disaster drills documented on 1st, 2nd, and 3rd shifts. Interview on 4/4/23 the Lead Qualified Professional (QP) stated: -Fire drills were completed once every month and disaster drills were completed once every quarter. -There were 3 shifts throughout the week. -1st shift was 7am - 3pm. -2nd shift was 3pm- 11pm. -3rd shift was 11pm- 7am. -Whatever documentation was present in the fire and disaster drill log was what the facility had completed.	V 114		
V 301	27G .1801 Intensive Res. Tx. Child/Adol - Scope 10A NCAC 27G .1801 SCOPE (a) An intensive residential treatment facility is one that is a 24-hour residential facility that provides a structured living environment within a system of care approach for children or adolescents whose needs require more intensive treatment and supervision than would be available in a residential treatment staff secure facility. (b) It shall not be the primary residence of an individual who is not a client of the facility. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, severe emotional and behavioral disorders or substance-related disorders; and	V 301		

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V 301	Continued From page 13 may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for acute inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to an intensive integrated treatment setting; and (2) treatment in a locked setting. (e) Services shall be designed to: (1) assist in the development of symptom and behavior management skills; (2) include intensive, frequent and pre-planned crisis management; (3) provide containment and safety from potentially harmful or destructive behaviors; (4) promote involvement in regular productive activity, such as school or work; and (5) support the child or adolescent in gaining the skills needed for reintegration into community living. (f) The intensive residential treatment facility shall coordinate with other individuals and agencies within the child or adolescent's system of care. This Rule is not met as evidenced by: Based on record review, observation, and interview, the facility failed to meet intensive treatment and supervision needs affecting 3 of 7 clients audited (clients #1, #2, and #10). The findings are:	V 301	V301: The facility will ensure all intensive clients are provided with a structured environment for intensive treatment and supervision. The facility will complete admission assessment to ensure that the client needs can be met within the facility. The admission screening will be completed prior to admission. The facility will update CCA within 30 days. Strategies should reflect PCP for current behaviors. All staff will be trained in PCP and CCA prior to client admission. QP's and Lead QP will receive training on how to follow policy and procedures. This will be monitored by weekly meetings to address all behaviors. The facility will make sure we are meeting the needs of the client. The team will discuss current behaviors, strengths, and weaknesses. The Therapist will make sure all strategies are for the client current behaviors.	May 4, 2023

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	MHL078-325	A. BUILDING: _____ B. WING _____	R 04/13/2023

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V 301	Continued From page 14 Finding #1: Review on 4/5/23 of client #2's record revealed: -17 year old male admitted to the facility on 3/20/23 and discharged 4/6/23. -Diagnoses included Attention Deficit Hyperactivity Disorder (ADHD), Conduct Disorder, and Post Traumatic Stress Disorder (PTSD). -Presenting problems, needs, or strategies for level IV services had not been identified or implemented by the facility. Review on 4/5/23 of client #2's treatment plan completed by his prior Level III Residential Group Home on 11/18/22 and updated on 1/20/23 revealed: -"Long Range Outcome" documented, "[client #2] reported that he wanted to stay out of trouble, join the military and go to college. [client #2] expressed that he wanted to join the Marines and follow in the footsteps of his cousins." -In the past year client #2 had 2 hospital evaluations for threats to harm himself. During one evaluation he said he wanted to kill his respite home provider. -The only information documented as "What's Working" for client #2: -"[Client #2] reported that little to nothing was working right now. [client #2] reported that having his aunt was positive as well and his cousins that he was raised with." -Disruptive behaviors had resulted in his "falling behind" in school and multiple placements over the last year, with 2 police responses in the past year. -Intentionally annoyed his peers on multiple occasions in his residential setting. -Was no longer "welcomed back" to his family after he stole and used credit cards during his December 2022 home visit.	V 301		

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V 301	Continued From page 15 -Had "recently" broken into cars and stole credit cards and computers. -Physical altercations or fighting with peers was not identified in his plan as a behavior. Review on 4/5/23 and 4/12/23 of facility incident reports for client #2 revealed: -No incident report for behaviors reported to his Department of Social Services (DSS) Guardian on 3/27/23 that were serious and could potentially result in his discharge. -3/30/23: Client #2 was in a "CPI (Crisis Prevention and Intervention Training) Holding Skill. Consumer kept pushing staff and trying to break things." -4/4/23: Client #2 became upset when client #3 called him "gay." Client #2 and client #10 were each "grabbed" by the staff in an effort to avoid a physical altercation between the 2 clients. While being held by staff, client #10 "broke away," and approached client #2. Client #7 hit client #2 in his back. A fight resulted between client #10 and client #2. Staff documented the incident occurred because client #2 was "bullying the younger boys." Review on 4/11/23 of email messages between client #2's DSS Guardian, LME/MCO (Local Management Entity/Managed Care Organization) Case Manager (CM), and the Lead Qualified Professional (QP) revealed: -3/27/23 at 6:08 pm: The DSS Guardian emailed the LME/MCO CM about a call received from the Lead QP on 3/27/23. The DSS Guardian wrote the Lead QP had "implied" client #2 would be discharged because he stated he wanted to "mix ammonia or bleach," did not want to be in the group home, and was bullying his peers. "Please give her a call to let her know that this type of behavior is normal for a level four facility. Can	V 301		

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V 301	Continued From page 16 you please talk to them and ask if they can keep him." -3/27/23 at 6:36 pm: The LME/MCO CM emailed the Lead QP and requested clarification of the need to discharge client #2. The LME/MCO CM wrote it was her understanding that client #2's behaviors were typical for behaviors a "level IV" should be able to handle. "We want to prevent disruption for [client #2] as he is literally just arrived there not even a week ago, but also historically it is very difficult to find placement for him. We three are a part of his care team---so let's collaborate on planning to prevent his disruption or admission to even higher level of care. Is there anyone else needing to be involved on his care team? I can seek help from my supervisor as well if needed." The LME/MCO CM explained an "enhanced rate" could be requested from the LME/MCO if additional staff were needed for the client. -3/29/23 at 8:56 am the Lead QP responded to the LME/MCO CM and DSS Guardian that the facility was interested in the enhanced rate for "one on one" staffing. -3/31/23 at 11:13 am: The LME/MCO CM responded to the Lead QP and DSS Guardian. The forms were sent to the Lead QP to request the enhanced rate. "Let's also collaborate to schedule an initial cft (child family team) meeting for [client #2] soon. Let me know what you all prefer for your cfts. I think we should schedule for mid-April if that works for you." -4/4/23 at 3:10 pm: The DSS Guardian emailed the LME/MCO CM, "I received a call from [Lead QP] stating a fight broke out at the facility and [client #2] won't let it go. He still wants to fight the consumers and is communicating threats. They separated everyone, the other consumers are outside... but [client #2] had to remain inside because he is still upset. Having said that, she	V 301		

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V 301	Continued From page 17 (Lead QP) wants to give a 5-day discharge. I still don't understand why [Lead QP] wants to discharge him because again that's why [client #2] is in a level 4 facility. Any thoughts? [LME/MCO CM] please call [Lead QP]." -4/4/23 at 3:51 pm: The LME/MCO CM sent an email to the Lead QP and copied the Program Director. The LME/MCO CM requested an update on the request for an enhanced rate and wrote she had been informed by the DSS Guardian of another potential discharge notice. -4/5/23 at 11:34 am: The LME/MCO CM emailed the Lead QP and DSS Guardian. The LME/MCO CM had been informed by the Lead QP the facility had decided against the enhanced rate and would be discharging client #2 because "they cannot keep the milieu safe... **Of course if there is anything further that the team can collaborate on to prevent the disruption, that would be ideal. I am willing to meet or have a phone conference if that is a possibility." -4/5/23 at 4:50 pm: The Lead QP's email to the LME/MCO CM read, "This will be an emergency 5 day discharged due to the health and safety of the clients... his discharge date will be on Sunday, April 9, 2023... the recommendation will be for a higher level of care." Review on 4/11/23 of Client #2's Discharge Summary dated 4/9/23 and signed by the Lead QP revealed: -The Renewing Grace Residential Team met on 4/4/23 to review and discuss client #2's "on-going escalation of behaviors since March 27, 2023." -The team agreed client #2 had caused "severe disruption" within the facility. -The team was concerned about the health and safety of peers in the facility. -On 4/4/23 client #2 became "agitated and aggressive toward peers."	V 301		

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V 301	Continued From page 18 -The staff were able to break up a physical altercation between client #2 and his peers and separated them, with client #2 inside the facility and the other peers outside the facility. -Client #2 continued to display agitation, made threats, and "busted the door open" trying to get outside to his peers. -He was moved out of the facility and into sister facility A, and was able to calm down. -During his admission he displayed several incidents of bullying his peers, profanity, and property destruction, non-compliance, physical aggression, blaming others, challenging staff authority, and making threats to elope. -After client #2 was relocated to sister facility A, he continued to challenge staff authority, property destruction, not listening to staff directions, and communicating threats about other peers. -Client #2 was an "emergency discharge within 5 days" and a higher level of care, PRTF (Psychiatric Residential Treatment for Children and Adolescents facility) was recommended. Observation on 4/5/23 at 3:30 pm revealed: -Client #2 was in sister facility A with 3 staff. -There were no other clients in the facility. -Client #2 was sitting at a table in the large open area watching television. -Client #2 was calm. Interview on 4/5/23 client #2 stated: -He had been at the facility for 2 weeks. -There had been "ups and downs." -He did not feel the facility had helped him; "Not sure what I need to help me." -Overall it had been "good here." -"I was restrained last week .... Nobody processed anything after that." -"I think I might have told [Licensed Professional]" about the restraint.	V 301		

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V 301	Continued From page 19 -With regards to 4/4/23 incident, "Kid called me a name and another kid got into the argument and then I said I'm not going to let you talk to me like that and we got into it." Interview on 4/11/23 client #2's LME/MCO CM stated: -The Lead QP informed her the facility needed 3 staff with client #2. -According to the Lead QP the facility could not keep client #2 because he became agitated. Interview on 4/13/23 client #2's DSS Guardian stated: -Client #2 had not been successful in a level III facility and his LME/MCO CM "felt like" Renewing Grace could help with his behaviors. -She had been told the fight was a "turning point" for the decision to discharge client #2. -Client #2 had never had an issue with fighting; he had never been in a fight. -The facility never informed her of any behaviors after the fight on 4/4/23. -Client #2 had never had any behaviors that posed a physical danger to others. -In the past he was in a facility with younger kids and there were complaints near the end of his stay that he would "bully the kids." -It was typical for client #2 to display behaviors when he wanted to get out of a facility. -She had requested the facility to refer back to his crisis plan. -It was typical for client #2 to "not let something go until it runs it course." -Client #2 felt like his peers had "jumped him" and "hurt his pride." -She was told client #2 made threats that "he was going to get the guys." -The DSS Guardian told staff that client #2 was "just talking. Don't take it lightly, but do not put	V 301		

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V 301	Continued From page 20 enough energy in it to scare you. He will not do anything else. If you keep an eye on him it will go away." -The discharge within 2 weeks of admission compromised the likelihood to find placement so close to his 18 th birthday when he would "age out" for service eligibility. -Client #2 looked at her not only as a guardian/social worker, but also his "support group." -If she could have called him they may have been able to "walk him through it," but the facility did not allow him to make or receive phone calls for the first 14 days of admission. Interview on 4/13/23 the DSS Supervisor stated: -She was familiar with client #2. -Client #2 had been discharged to a respite facility. She and the DSS Guardian were concerned because client #2 had no services available in that setting. -Client #2 needed services and a plan for after care because he will soon turn 18 years old. -They had spoken with his aunt, his prior guardian, and she was not willing to let him return to the home. Finding #2: Review on 4/5/23 of Client #1's record revealed: -9 year old male admitted to the facility on 3/20/23. -Diagnoses included ADHD, combined type; Oppositional Defiant Disorder (ODD); Autism Spectrum Disorder; and Intellectual Disability. -Presenting problems, needs, or strategies for level IV services had not been identified or implemented by the facility. Review on 4/5/23 of Client #1's Clinical Evaluation at his prior facility dated 3/6/23	V 301		

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V 301	Continued From page 21 revealed: -History of anxiety, sleep changes, poor hygiene, verbal aggression, non-compliance, self-injurious behaviors, physical aggression, poor impulse control, and hyperactivity. -Barriers to treatment included unhealthy coping skills, limited insight/judgement, social problems, relational problems, little/no family support, trauma history, and cognitive deficits. -Medical issues included enuresis and insomnia. Review on 4/5/23 of the facility incident reports for client #1 revealed: -3/22/23 at 3:15 pm client #1 became defiant and refused to return to his room during "consumer downtime (3:00-4:00)." Staff escorted him to his room and instructed him to clean his room. He refused and was placed in a "CPI" (Crisis Prevention Institute) hold when he began spitting, cursing at staff, and biting himself. -3/23/23 at 3:50 pm client #1 was told he needed to clean his room. This occurred during "downtime," client #1 "instantly got upset" and was placed in a "CPI" hold when he started kicking the wall, banged his head on the floor, cursed, screamed, and said the staff were hurting him, pinching him, and trying to "kill" him ... "He would calm down and then quickly start throwing a behavior again. He did this several times and each time he did, staff was forced to put him in a CPI hold. The Consumer started to bite himself and hit his head against the wall and punch his head." -3/24/23 at 3:30 pm client #1 refused to clean his room when asked by the facility manager. He was placed in a "CPI" hold after he started to kick, bite himself, and "fight." -3/31/23 at 4:40 pm client #1 was placed in a "CPI" hold after he began kicking the door and biting himself when he was not allowed to return	V 301		

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V 301	Continued From page 22 indoors. -4/3/23 at 7:40 pm client #1 refused to take a shower and was placed in a "CPI" hold after he began to destroy his room, spit and cursed at staff, and started to bite himself. -There was no documentation the DSS Guardian had been notified or included in a debrief of any of the restrictive interventions to identify strategies to reduce the likelihood for further restrictive interventions. Review on 4/13/23 of the North Carolina Incident Response and Improvement System revealed client #1 had been placed in a restraint on 4/6/23 at 3:30 pm for "aggressive behavior." Review on 4/13/23 of client #1's "Complete Evaluation/Intake" summary by the Licensed Professional dated 3/23/23 revealed: -Members of the Licensee's Interdisciplinary Team met on 3/23/23 to review and discuss Client #1's placement at the facility. -The following disruptive behaviors were described: -Arguing with staff and peers -Excessive profanity use -Biting and scratching himself -Refusing to allow staff to help him change his incontinence brief -Rolling on the floor, throwing objects, hitting staff and peers -Screaming -Refusing to take a shower on 3/22/23. Staff directed him back to his room and suggested he clean his room. He told staff "i only been here 2 days I don't know how to make the bed and you know that." -"Exam: [Client #1] appears friendly, inattentive, distracted, but appears anxious. He exhibits speech that is normal ... coherent and	V 301		

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V 301	Continued From page 23 spontaneous... Easy distractibility and a short attention span are in evidence. Signs of manic psychosis appear to be present. Affect is appropriate... There are no apparent signs of hallucinations, delusions, bizarre behaviors, or other indicators of psychotic process. ... [Client #1] is fidgety... physical hyperactivity... displayed some defiant behavior during the examination." -"Therapy Content/Clinical Summary: The Members of Renewing Grace/Carter Clinic interdisciplinary agree that [Client #1] will benefit from a long-term care an ICF/IDD (Intermediate Care Facility for Individuals with Intellectual Disabilities) facility to assist with his needs. This arrangement is one that cannot be facilitated by Renewing Grace as a level IV facility. For continuity of care, Renewing Grace will be discharging [Client #1] to his legal guardian and have agreed to follow up for continuity of care regarding paperwork, but cannot house [Client #1] at the facility. A post discharge meeting will be scheduled for five days from the date of this immediate discharge." Interview on 4/5/23 Client #1 stated: -He had been at the facility for 20 days. -He had not made any friends. -He denied having been put in a restrictive intervention. Interview on 4/13/23 Client #1's DSS Guardian stated: -The DSS Guardian was called after 3 days in the facility and given notice of discharge because of the client #1's behaviors. -After discussions the facility agreed to keep client #1 for the enhanced rate. -The behaviors the facility reported were behaviors the facility had been told about prior to his admission.	V 301		

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V 301	Continued From page 24 -The behaviors included client #1 would "poop" on himself, shut down when told no, hit his peers, throw "stuff," and bite himself. -Client #1 had stayed in the DSS office or with a foster parent on the weekends for 2 weeks as they looked for a placement. -Some of the behaviors the facility reported had not been seen while at DSS or in the foster home prior to his admission. -She told the facility Client #1 had the ability to refrain from the behaviors they reported and she could not understand why the facility staff could not handle him along with the QPs and therapist. -A Comprehensive Clinical Assessment (CCA) had been sent to the facility prior to admission and she believed wearing "pull ups" was in the plan. -Client #1 had not required restrictive interventions while he stayed at DSS awaiting placement. -The first CFT (Child Family Team) meeting was planned "next week." -She had not been notified that client #1 had been put in any restrictive interventions. Finding #3: Review on 4/4/23 and 4/6/23 of client #10's record revealed: -17 year old male admitted to the facility on 4/2/23. -Diagnoses included Conduct Disorder, Disruptive Mood Dysregulation Disorder (DMDD), and Major Depressive Disorder. -Presenting problems, needs, or strategies for level IV services had not been identified or implemented by the facility. Review on 4/4/23 and 4/6/23 of client #10's treatment plan completed 1/10/23 by his prior PRTF provider revealed:	V 301		

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V 301	Continued From page 25 -Client #10 had been admitted to the PRTF for stabilization and assessment services. -In February 2023 he "first engaged in a verbal altercation with peer, approached peer and assaulted him. He then returned to his area, got into a verbal altercation with his roommate and this lead into a physical altercation. He was then placed on Aggression Protocol." -On 3/13/23 client #10's CFT discussed the need for PRTF placement to address his anger. He had been given a notice of discharge effective 4/3/23 and he had not been accepted for admission by any PRTF. -On 3/24/23 client #10's plan was updated "to reflect transition to Level IV Renewing Grace Residential Home." Interview on 4/5/23 client #10 stated: -He was in a physical altercation with client #2 on 4/4/23. -Client #2 "started this" by "bullying" the younger "kids." -Staff intervened and tried to get Client #10 off of client #2. -One staff "grabbed" him (Client #10) and and someone else "grabbed" client #2. -He heard client #2 was not coming back. Interview on 4/13/23 client #10's Guardian stated: -Client #10 had been in a PRTF prior to his admission on 4/2/23. -The PRTF recommended further PRTF placement because he was "too aggressive" and "trying to get into fights;" however, an accepting PRTF could not be found. -She agreed to his current placement because there were no other facility options. -The facility had not informed her of any restrictive interventions since his admission on 4/2/23.	V 301		

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V 301	Continued From page 26 Interview on 4/11/23 QP #2 stated: -She worked the evening shift. -Before 4/4/23 client #2 had been "quiet" and she never saw that he was a "threat." -She was 1 of 3 staff with client #2 for 1 shift after he was relocated to sister facility A. -During her shift at sister facility A she had no issues with client #2, he was "calm," and said "he liked being by himself." Interview on 4/4/23 and 4/5/23 the Lead QP stated: -Before a client was admitted the facility would obtain information from the LME/MCO. -She would complete a face sheet. -After 30 days she would have a CFT meeting to review goals, problems, and behaviors. -There had been a fight on 4/4/23 between "mainly" client #2 and Client #10. -The fight occurred while the clients were outdoors; it was "violent and quick." -After the fight client #2 continued to make threats. -Client #2 had been relocated to sister facility A with 3 staff. -The Guardian had been notified and was given a verbal 5 day notice. -The plan was to "maybe" keep him in sister facility A until his discharge. -On 4/5/23 he remained in sister facility A. -The facility had decided against taking client #2 for a hospital evaluation because his behaviors would not be a reason to admit him and he would be discharged back to the facility. Interview on 4/6/23 and 4/13/23 the Director stated: -Client #2's social worker had arranged for him to be transferred on 4/6/23.	V 301		

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V 301	Continued From page 27 -His Guardian was "trying to figure out what is going on with him." -His DSS Guardian has had this same problem with client #2 in the past; "He will do something and then act like he did nothing." -She agreed the facility should have an admission screening and assessment process to avoid accepting clients whose needs they could not meet. -The Psychiatrist/Licensee said they were going to come up with a different plan if clients "act out." -The police and hospital have not been responsive when clients had been taken to the emergency room in crisis. -The plan moving forward will be for the Psychiatrist/Licensee to be contacted and he would "interface" with the hospital physicians. Review on 4/13/23 of a Plan of Protection completed 4/13/23 and signed by the Residential Director revealed: - "What immediate action will the facility take to ensure the safety of the consumers in your care? The facility will ensure all intensive Clients are provided with Structured environment for intensive treatment and supervision. The facility will complete admission assessment to ensure that the client needs can be met Within the facility. The admission screening will be Completed prior to admission. The facility will update CCA within 30 days. Strategies should reflect PCP (Person Centered Profile) for Current Behaviors. All staff will be trained on PCP and CCA prior to Client Admission. QP will receive Training on how to follow policy & procedures. -Describe your plans to make sure the above happens. We have weekly meetings to address all behaviors. The facility will make sure we are meeting the Clients Needs. The teams will discuss Current behaviors, Strengths and	V 301		

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V 301	Continued From page 28 weakness. The therapist will make Sure all strategies are for the Client Current behaviors." Clients #1, #2, and #10, ages 9, 17, and 17 respectively, presented with diagnoses to include ADHD, ODD, Conduct Disorder, Depressive Disorder, DMDD, IDD and PTSD. Client #2, who was aging out of service eligibility, was issued an emergency discharge on 4/4/23 following a physical altercation with a peer. Client #1, who had a history of difficult behaviors, was issued a notice of discharge 3 days after admission for behaviors consistent with his past experiences. The discharge was later rescinded and client #1 was later placed in 5 physical restraints between 3/23/23 - 4/6/23. Client #10, who had a history of physical altercations with peers, was involved in a physical altercation with a peer on 4/4/23 leading to a restrictive intervention and no processes in place to prevent future occurrences. The clients did not have strategies in place based on assessed needs when admitted to ensure services addressed behavior management, crisis management, safety from destructive behaviors, or skills toward reintegration into the community. This deficiency constitutes a Continued Failure to Correct Type A1 rule violation originally cited for serious neglect. An administrative penalty of $500.00 per day continues to be imposed for failure to correct within 23 days.	V 301		
V 364	G.S. 122C- 62 Additional Rights in 24 Hour Facilities § 122C-62. Additional Rights in 24-Hour Facilities. (a) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-61, each adult client who is receiving treatment or habilitation in a	V 364		

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V 364	Continued From page 29 24-hour facility keeps the right to: (1) Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary; (2) Contact and consult with, at his own expense and at no cost to the facility, legal counsel, private physicians, and private mental health, developmental disabilities, or substance abuse professionals of his choice; and (3) Contact and consult with a client advocate if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each adult client may exercise these rights at all reasonable times. (b) Except as provided in subsections (e) and (h) of this section, each adult client who is receiving treatment or habilitation in a 24-hour facility at all times keeps the right to: (1) Make and receive confidential telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over therapies; (3) Communicate and meet under appropriate supervision with individuals of his own choice upon the consent of the individuals; (4) Make visits outside the custody of the facility unless: a. Commitment proceedings were initiated as the result of the client's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found not guilty by reason of insanity or incapable of proceeding; b. The client was voluntarily admitted or	V 364		

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V 364	Continued From page 30 committed to the facility while under order of commitment to a correctional facility of the Division of Adult Correction of the Department of Public Safety; or c. The client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; A court order may expressly authorize visits otherwise prohibited by the existence of the conditions prescribed by this subdivision; (5) Be out of doors daily and have access to facilities and equipment for physical exercise several times a week; (6) Except as prohibited by law, keep and use personal clothing and possessions, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Keep and spend a reasonable sum of his own money; (9) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes; and (10) Have access to individual storage space for his private use. (c) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-57 and G.S. 122C-59 through G.S. 122C-61, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to have access to proper adult supervision and guidance. In recognition of the minor's status as a developing individual, the minor shall be provided opportunities to enable him to mature physically, emotionally, intellectually, socially, and vocationally. In view of the physical, emotional, and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate structure, supervision and control consistent with the rights given to the minor pursuant to this Part.	V 364		

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V 364	Continued From page 31 The facility shall also, where practical, make reasonable efforts to ensure that each minor client receives treatment apart and separate from adult clients unless the treatment needs of the minor client dictate otherwise. Each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to: (1) Communicate and consult with his parents or guardian or the agency or individual having legal custody of him; (2) Contact and consult with, at his own expense or that of his legally responsible person and at no cost to the facility, legal counsel, private physicians, private mental health, developmental disabilities, or substance abuse professionals, of his or his legally responsible person's choice; and (3) Contact and consult with a client advocate, if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each minor client may exercise these rights at all reasonable times. (d) Except as provided in subsections (e) and (h) of this section, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to: (1) Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Send and receive mail and have access to writing materials, postage, and staff assistance when necessary; (3) Under appropriate supervision, receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over school or therapies; (4) Receive special education and vocational	V 364		

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V 364	Continued From page 32	V 364		

training in accordance with federal and State law;
(5) Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with his needs;
(6) Except as prohibited by law, keep and use personal clothing and possessions under appropriate supervision, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002;
(7) Participate in religious worship;
(8) Have access to individual storage space for the safekeeping of personal belongings;
(9) Have access to and spend a reasonable sum of his own money; and
(10) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes.
(e) No right enumerated in subsections (b) or (d) of this section may be limited or restricted except by the qualified professional responsible for the formulation of the client's treatment or habilitation plan. A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional at least every seven days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's record. Restrictions on rights may be renewed only by a written statement entered by the qualified professional in the client's record that states the reason for the renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal of a restriction of rights, an individual designated by the client shall, upon the consent of the client,

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V 364	Continued From page 33 be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction or renewal of a restriction of rights and of the reason for it. Notification of the designated individual or legally responsible person shall be documented in writing in the client's record. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility restricted the rights of 7 of 7 clients audited (#1, #2, #6, #7,#9, #10, and #11) by restricting their access to make and receive telephone calls. The findings are: Review on 4/5/23 of client #1's record revealed: -9 year old male admitted to the facility on 3/20/23. -Diagnoses included Attention Deficit Hyperactivity Disorder (ADHD), combined type; Oppositional Defiant Disorder (ODD); and Intellectual Disability. -No documentation regarding the restriction of client #1's right to make or receive phone calls. Review on 4/5/23 of client #2 record revealed: -17 year old male admitted to the facility on 3/20/23. -Diagnoses included ADHD, Conduct Disorder, and Post Traumatic Stress Disorder (PTSD). -No documentation regarding the restriction of client #2's right to make or receive phone calls. Review on 4/4/23 of client #6's record revealed:	V 364	V364: The facility will ensure documentation is provided in each Person-Centered Plan regarding restriction of client rights to make or receive phone calls. The restriction will be effective no more than 14 days at which time the restriction will be removed. QP's will monitor weekly and Lead QP will monitor monthly.	June 3, 2023

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V 364	Continued From page 34 -17 year old male admitted to the facility on 2/21/23. -Diagnoses included ADHD and Borderline Intellectual Functioning. -No documentation regarding the restriction of client #6's right to make or receive phone calls. Review on 4/4/23 of client #7's record revealed: -14 year old male admitted to the facility on 2/22/23. -Diagnoses included ADHD and Generalized Anxiety Disorder (GAD). -No other documentation regarding the restriction of client #7's right to make or receive phone calls. Review on 4/5/23 of client #9's record revealed: -10 year old male admitted to the facility on 3/30/23. -Diagnoses included ADHD and ODD. -No other documentation regarding the restriction of client #9's right to make or receive phone calls. Review on 4/4/23 of client #10's record revealed: -17 year old male admitted to the facility on 4/2/23. -Diagnoses included Conduct Disorder, Disruptive Mood Dysregulation Disorder (DMDD), and Major Depressive Disorder. -No other documentation regarding the restriction of client #10's right to make or receive phone calls. Review on 4/12/23 of client #11's record revealed: -15 year old male admitted to the facility on 4/5/23. -Diagnoses included DMDD, ADHD, ODD, and Persistent Depressive Disorder. -No other documentation regarding the restriction of client #11's right to make or receive phone calls.	V 364		

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V 364	Continued From page 35 Interview on 4/13/23 client #2's Department of Social Services (DSS) Guardian stated: -It was a policy that clients could not make phone calls or receive visitors for the first 14 days after admission. -The phone call and visitor restriction was verbalized at the time of admission. Interview on 4/13/23 client #6's guardian stated: -She was informed that client #6 could not make or receive phone calls for the first 14 days after admission. -She had to contact the Qualified Professional (QP) in order to get an update on how client #6 was adjusting to the program. Interview on 4/13/23 client #9's guardian stated: -He was made aware that client #9 could not make or receive phone calls for the first 14 days after admission when client #9's mother attempted to visit. The facility allowed for the visitation to proceed due to the mother only being 1 day shy of the 14 required days Interview on 4/13/23 client #10's guardian stated: -She was told it was a policy that clients could not make phone calls or receive visitors for the first 14 days after admission. Interview on 4/13/23 client #11's guardian stated: -She was told by the Lead QP that she could have no contact with client #11 for the first 14 days after admission. -Following the 14th day after admission, client #11 would be allowed evening phone calls between 4pm - 6pm during the week and 10am - 6pm on the weekends. Interview on 4/12/23 the House Manager stated:	V 364		

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V 364	Continued From page 36 -The clients were not allowed to make or receive phone calls for the first 14 days following admission. -Phone policy was introduced upon admission. Interview on 4/13/23 the Lead QP stated: -The clients were not allowed to make or receive phone calls for the first 14 days following admission. -The clients were not allowed to have any visitors for the first 14 days following admission. -Clients were not allowed home visits.	V 364		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding	V 366		

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V 366	Continued From page 37 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 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	V 366		

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(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 366	Continued From page 38 located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement written policies	V 366	V366: The facility will ensure QP's are responsible to document restrictive interventions and make sure the health and safety needs are reported to the RN immediately. The Lead QP will monitor daily. The RN followed up by completing a note with findings within 24 hours.	June 3, 2023

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V 366	Continued From page 39 governing their response to incidents as required. The findings are: Finding #1: Review on 4/5/23 of client #1's record revealed: -9 year old male admitted to the facility on 3/20/23. -Diagnoses included Attention Deficit Hyperactivity Disorder (ADHD), combined type; Oppositional Defiant Disorder (ODD); Autism Spectrum Disorder; and Intellectual Disability. -The use of restrictive interventions was not documented as a planned intervention. Review on 4/5/23 of the facility incident reports for client #1 revealed: -"CPI" (Crisis Prevention Institute) holds were documented on 3/22/23 at 3:15 pm, 3/23/23 at 3:50 pm, 3/24/23 at 3:30 pm, 3/31/23 at 4:40 pm, and 4/3/23 at 7:40 pm. -None of the restrictive interventions had been documented as level II incidents. -There was no documentation that the health and safety needs of client #1 had been addressed after the incident on 3/23/23 at 3:50 pm. Finding #2: Review on 4/5/23 of client #2's record revealed: -17 year old male admitted to the facility on 3/20/23. -Diagnoses included ADHD, Conduct Disorder, and Post-Traumatic Stress Disorder (PTSD). -The use of restrictive interventions was not documented as a planned intervention. Review on 4/11/23 of emails between client #2's Department of Social Services (DSS) Guardian and LME/MCO (Local Management Entity/Managed Care Organization) Case Manager (CM) revealed:	V 366		

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V 366	Continued From page 40 -3/27/23 at 6:08 pm: The DSS Guardian emailed the LME/MCO CM about a call received from the Lead QP on 3/27/23. The DSS Guardian wrote the Lead Qualified Professional (QP) had "implied" client #2 would be discharged because he stated he wanted to "mix ammonia or bleach," did not want to be in the group home, and was bullying his peers. "Please give her a call to let her know that this type of behavior is normal for a level four facility. Can you please talk to them and ask if they can keep him." Review on 4/5/23 and 4/12/23 of the client #2's facility incident reports revealed: -3/27/23: No incident reports for client #2's serious behaviors that could lead to discharge. -3/30/23: At 5:00 pm client #2 was in a "CPI Holding Skill. Consumer kept pushing staff and trying to break things." -4/4/23: At 11:00 am staff "grabbed" client #2 and client #10 to separate them during a verbal altercation. Client #10 "got away" from the staff and "ran up to [client #2] and then they started fighting." Client #7 "proceeded to hit [client #2] in the back." Client #2 received 2 scratches on his face and client #10 had a scratch on his back. -There were no level II incident reports for the use of emergency restrictive interventions for client #2 on 3/30/23 or 4/4/23. -There was no documentation the health and safety needs of client #2 were addressed following the incidents on 3/30/23 or 4/4/23. Finding #3: Review on 4/4/23 of client #10's record revealed: -17 year old male admitted to the facility on 4/2/23. -Diagnoses included Conduct Disorder, Disruptive Mood Dysregulation Disorder (DMDD), and Major Depressive Disorder.	V 366		

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V 366	Continued From page 41 -The use of restrictive interventions was not documented as a planned intervention. Review on 4/5/23 of facility incident reports for 4/4/23 revealed no incident report for client #10's behaviors or restrictive intervention on 4/4/23 with client #2. Finding #4: Review on 4/4/23 of client #6's record revealed: -17 year old male admitted to the facility on 2/21/23. -Diagnoses included ADHD and Borderline Intellectual Functioning. Interview on 4/14/23 a dispatcher from the local law enforcement revealed officers responded on 3/31/23 to a call about a client "walking up 3rd street." Interview on 4/4/23 client #6 stated he eloped but denied seeing local law enforcement on site. Interview on 4/4/23 the Lead Qualified Professional stated: -Police had responded to client #6's elopement the week of 3/27/23. -There had been a fight on 4/4/23 between "mainly" client #2 and client #10 when the clients were outside. -The fight was "violent and quick." -Both clients received scratches during the physical altercation. -The Director had been called to come to the facility in case extra staff was needed. -Client #2 continued to make threats after the fight ended. -Client #2 had been relocated to sister facility A and may remain there until he was discharged. -Client #2's guardian had been called and given a	V 366		

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V 366	Continued From page 42 verbal 5 day notice of discharge. -There were no plans to send client #2 to the hospital for evaluation because, based on previous experience, the emergency room physicians would not admit client #2 for his behaviors and he would be released back to the facility.	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: (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	V 367		

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V 367	Continued From page 43 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 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;	V 367		

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V 367	Continued From page 44 (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 reviews and interviews, the facility failed to report all level II incidents to the LME/MCO (Local Management Entity/Managed Care Organization) within 72 hours of becoming aware of the incident or submit other information upon request by the LME/MCO. The findings are: Refer to V366 for the following incidents: -Local law enforcement reported a response to the facility 3/31/23 for elopement. -Client #1 had been placed in 5 emergency restrictive interventions between 3/22/23 and 4/3/22. -Client #2 had been placed in an emergency restrictive interventions on 3/30/23 and 4/4/23. -Client #10 had been placed in an emergency restrictive intervention on 4/4/23 -On 4/4/23 there was a fight involving client #2, client #10, and client #7 that resulted in the removal and 5 day notice of discharge of client #2	V 367	V367: The facility will ensure all Level II's and Level III's incident reports are reported to the NC IRIS within 72 hours of becoming aware of the incident.	May 4, 2023

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V 367	Continued From page 45 from the facility. Review on 4/12/23 of the North Carolina Incident Response Improvement System (IRIS) reports from 1/1/23 - 4/12/23 revealed: -No level II incident reports for local law enforcement contact. -No level II incident reports for the use of emergency restrictive interventions of client #1, client #2, or client #10. -No level II incident report for client #10 on 4/4/23 when he engaged in a physical fight with client #2. -No level II incident report for client #7 on 4/4/23 when he hit client #2 in the back. -4/9/23: Two level II incident reports had been submitted for the use of emergency restrictive interventions as follows: -Client #8: 4/6/23 at 5:45 pm for aggressive behavior. -Client #1: 4/6/23 at 3:30 pm for aggressive behavior. -Questions for the Restrictive Intervention tab had not been completed for either one of the level II reports for the use of restrictive interventions on 4/6/23. -On 4/11/23 The MCO/LME had requested that all of the applicable questions on the "Restrictive Intervention" tab to be completed for each report submitted on 4/9/23 for the use of restrictive interventions on 4/6/23. Interview on 4/12/23 the Lead Qualified Professional stated: -There had been one incident of an elopement that resulted in police contact. -She did not realize that police contact required level II incident reporting. -There had been four restrictive interventions on 4/6/23.	V 367		

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V 367	Continued From page 46 -Following the opening of the state survey on 4/5/23, the reports had been reported in the IRIS system. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 367		
V 518	27E .0104(e1-2) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (1) the requirement that positive and less restrictive alternatives are considered and attempted whenever possible prior to the use of more restrictive interventions; (2) consideration is given to the client's physical and psychological well-being before, during and after utilization of a restrictive intervention, including: (A) review of the client's health history or the client's comprehensive health assessment conducted upon admission to a facility. The health history or comprehensive health assessment shall include the identification of pre-existing medical conditions or any disabilities and limitations that would place the client at greater risk during the use of restrictive interventions; (B) continuous assessment and monitoring of the physical and psychological well- being of the client and the safe use of restraint throughout the duration of the restrictive intervention by staff who are physically present and trained in the use of emergency safety interventions;	V 518		

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V 518	Continued From page 47 (C) continuous monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being during the use of manual restraint; and (D) continued monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being for a minimum of 30 minutes subsequent to the termination of a restrictive intervention; This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to develop and implement policy and procedures for restrictive interventions as required. The findings are: Review on 4/5/23 of the facility policy for restrictive interventions revealed the following requirements were not included: -Consideration of the client's physical and psychological well-being before, during and after utilization of a restrictive intervention, including a review of the client's health history or the client's comprehensive health assessment conducted upon admission to a facility. -Continuous assessment and monitoring of the physical and psychological well- being of the client and the safe use of restraint throughout the duration of the restrictive intervention by staff who are physically present and trained in the use of cardiopulmonary resuscitation -Continued monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being for a minimum of 30 minutes subsequent to the termination of a restrictive intervention.	V 518	V518: The facility will ensure that the policy and procedure will be developed to reflect restrictive interventions. Staff, QP's and Lead QP will be trained on restrictive interventions policy and procedures monthly. This will be monitored by the Residential Director monthly.	June 3, 2023

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V 518	Continued From page 48 Interview on 4/5/23 the Lead Qualified Professional stated: -"Least Restrictive Alternative," dated 10/8/2018, was the only facility policy for restrictive interventions.	V 518		
V 519	27E .0104(e3-7) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (3) the process for identifying, training, assessing competence of facility employees who may authorize and implement restrictive interventions; (4) the duties and responsibilities of responsible professionals regarding the use of restrictive interventions; (5) the person responsible for documentation when restrictive interventions are used; (6) the person responsible for the notification of others when restrictive interventions are used; and (7) the person responsible for checking the client's physical and psychological well-being and assessing the possible consequences of the use of a restrictive intervention and, in such cases there shall be procedures regarding: (A) documentation if a client has a physical disability or has had surgery that would make affected nerves and bones sensitive to injury; and (B) the identification and documentation of alternative emergency procedures, if needed;	V 519		

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V 519	Continued From page 49 This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to develop and implement policy and procedures for restrictive interventions as required. The findings are: Review on 4/5/23 of the facility policy for restrictive interventions revealed the following requirements were not included: -The process for identifying, training, assessing competence of facility employees who may authorize and implement restrictive interventions. -The duties and responsibilities of responsible professionals regarding the use of restrictive interventions. -The person responsible for documentation when restrictive were used. -The person responsible for the notification of others when restrictive interventions are used. -The person responsible for checking the client's physical and psychological well-being and assessing the possible consequences of the use of a restrictive intervention. -Procedures for documentation if a client had a physical disability or has had surgery that would make affected nerves and bones sensitive to injury. -Procedures for the identification and documentation of alternative emergency procedures, if needed. Interview on 4/5/23 the Lead Qualified Professional stated: -"Least Restrictive Alternative," dated 10/8/2018, was the only facility policy for restrictive interventions.	V 519	519: The facility will revised the policy and procedure for restrictive interventions to reflect the process of identifying, training, assessing competence of facilities employees on who may authorize and implement restrictive interventions; the duties and responsibilities of responsible professionals regarding the use of restrictive interventions; the person responsible for documentation when restrictive were used; the person responsible for the notification of others when restrictive intervention are used; the person responsible for checking the client's physical and psychological well-being and assessing the possible consequences of the use of a restrictive intervention; procedures for documentation if a client had a physical disability or has had surgery that would make affected nerves and bones sensitive to injury; procedures for the identification and documentation of alternatives emergency procedures. This revised and updated as needed by administrative team as needed. Staff will be trained on revised policy.	June 3, 2023

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V 521	Continued From page 50	V 521		
V 521	27E .0104(e9) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (9) Whenever a restrictive intervention is utilized, documentation shall be made in the client record to include, at a minimum: (A) notation of the client's physical and psychological well-being; (B) notation of the frequency, intensity and duration of the behavior which led to the intervention, and any precipitating circumstance contributing to the onset of the behavior; (C) the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used; (D) a description of the intervention and the date, time and duration of its use; (E) a description of accompanying positive methods of intervention; (F) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions; (G) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and (H) signature and title of the facility employee who initiated, and of the employee who further	V 521		

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V 521	Continued From page 51 authorized, the use of the intervention. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to document the minimum requirements for restrictive interventions in the client's record affecting 6 of 7 clients audited (clients #1, #2, #6, #7, #9, #10). The findings are: Finding #1: Review on 4/5/23 and 4/12/23 of client #1's record revealed: -9 year old male admitted to the facility on 3/20/23. -Diagnoses included Attention Deficit Hyperactivity Disorder (ADHD), combined type; Oppositional Defiant Disorder (ODD); Autism Spectrum Disorder; and Intellectual Disability. -The use of restrictive interventions was not documented as a planned intervention. -No documentation of restrictive interventions in the client's record. Review on 4/5/23 of the client #1's facility incident reports revealed: -Client #1 had been placed in "CPI" (Crisis Prevention Institute) holds on 3/22/23 at 3:15 pm, 3/23/23 at 3:50 pm, 3/24/23 at 3:30 pm, 3/31/23 at 4:40 pm, and 4/3/23 at 7:40 pm. Review on 4/12/23 of client #1's North Carolina Incident Response Improvement System (IRIS) reports revealed client #1 had been put in a restrictive intervention on 4/6/23 at 3:30 pm for aggressive behavior. Finding #2: Review on 4/5/23 of client #2's record revealed:	V 521	V521: The facility will ensure to document the minimum requirements for restrictive interventions in all client's record. This will be monitored daily by QP's, Lead QP weekly and Residential Director monthly.	5/4/23

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	MHL078-325	A. BUILDING: _____ B. WING _____	R 04/13/2023

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V 521	Continued From page 52 -17 year old male admitted to the facility on 3/20/23. -Diagnoses included ADHD, Conduct Disorder, and Post Traumatic Stress Disorder (PTSD). -The use of restrictive interventions was not documented as a planned intervention. -No documentation of restrictive interventions in the client's record. Review on 4/5/23 of the client #2's facility incident reports revealed: -Client #2 had been placed in a "CPI Holding Skill" on 3/30/23 at 5:00 pm. -Client #2 and client #10 had been "grabbed" by staff on 4/4/23 at 11:00 am during a verbal altercation that went on to be a physical altercation. Finding #3: Review on 4/4/23 and 4/12/23 of client #6's record revealed: -17 year old male admitted to the facility on 2/21/23. -Diagnoses included ODD; ADHD, combined; Borderline Intellectual Functioning -No documentation of restrictive interventions in the client's record. Review on 4/5/23 and 4/12/23 of client #6's facility incident reports revealed client #6 was placed in a "CPI hold" on 3/24/23. Finding #4: Review on 4/4/23 and 4/12/23 of client #7's record revealed: -14 year old male admitted to the facility on 2/22/23. -Diagnoses included Generalized Anxiety Disorder; ADHD, unspecified. -No documentation of restrictive interventions in	V 521		

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V 521	Continued From page 53 the client's record. Review on 4/5/23 and 4/12/23 of client #7's facility incident reports revealed client #7 was "grabbed" and "removed" by staff on 3/24/23 following an attempted punch aimed at staff. Review on 4/12/23 of IRIS reports from 1/1/23 - 4/12/23 revealed client #7 was placed in a restrictive intervention on 4/6/23 at 5:50 pm for aggressive behavior. Finding #5: Review on 4/4/23 and 4/12/23 of client #9's record revealed: -10 year old male admitted to the facility on 3/30/23. -Diagnoses included ODD and ADHD. -No documentation of restrictive interventions in the client's record. Review on 4/5/23 and 4/12/23 of client #9's facility incident reports revealed: -Client #9 had been placed in a "CPI hold" on 4/4/23 at 10:00 am. -Client #9 had been placed in a "CPI hold" on 4/10/23 at 4:00 pm, 5:10 pm, and 7:00 pm. Review on 4/12/23 of IRIS reports from 1/1/23 - 4/12/23 revealed client #9 was placed in a restrictive intervention on 4/6/23 at 5:45 pm for aggressive behavior. Finding #6: Review on 4/4/23 and 4/12/23 of client #10's record revealed: -17 year old male admitted to the facility on 4/2/23. -Diagnoses included Conduct Disorder, Disruptive Mood Dysregulation Disorder (DMDD),	V 521		

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V 521	Continued From page 54 and Major Depressive Disorder. -The use of restrictive interventions was not documented as a planned intervention. -No documentation of restrictive interventions in the client's record. Review on 4/5/23 the facility incident report dated 4/4/23 revealed: -Client #10 had to be "grabbed" by staff to separate him from client #2 during a verbal altercation that progressed to a physical altercation. Interview on 4/5/23 the Lead Qualified Professional stated: -Information about restrictive interventions was not documented in a client's record. -A facility incident report would be completed if a client was placed in a restraint. -She "believed" the facility was in compliance for the rules regarding restrictive interventions. This deficiency is cross-referenced into 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS(Tag V109) for a Standard Deficiency rule violation and must be corrected within 30 days.	V 521		
V 522	27E .0104(e10) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (10) The emergency use of restrictive	V 522		

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 522	Continued From page 55 interventions shall be limited, as follows: (A) a facility employee approved to administer emergency interventions may employ such procedures for up to 15 minutes without further authorization; (B) the continued use of such interventions shall be authorized only by the responsible professional or another qualified professional who is approved to use and to authorize the use of the restrictive intervention based on experience and training; (C) the responsible professional shall meet with and conduct an assessment that includes the physical and psychological well-being of the client and write a continuation authorization as soon as possible after the time of initial employment of the intervention. If the responsible professional or a qualified professional is not immediately available to conduct an assessment of the client, but concurs that the intervention is justified after discussion with the facility employee, continuation of the intervention may be verbally authorized until an on-site assessment of the client can be made; (D) a verbal authorization shall not exceed three hours after the time of initial employment of the intervention; and (E) each written order for seclusion, physical restraint or isolation time-out is limited to four hours for adult clients; two hours for children and adolescent clients ages nine to 17; or one hour for clients under the age of nine. The original order shall only be renewed in accordance with these limits or up to a total of 24 hours. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to obtain orders or assessments by a responsible professional following the	V 522	V522: The facility will ensure to obtain orders or assessments by Licensed Professional following the emergency use of a restrictive intervention. This will be monitored daily by QP's and Lead QP daily.	May 4, 2023

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V 522	Continued From page 56 emergency use of a restrictive intervention affecting 3 of 7 clients audited (clients #1, #2, and #10). The findings are: Finding #1: Review on 4/5/23 and 4/12/23 of client #1's record revealed: -9 year old male admitted to the facility on 3/20/23. -Diagnoses included Attention Deficit Hyperactivity Disorder (ADHD), combined type; Oppositional Defiant Disorder (ODD); Autism Spectrum Disorder; and Intellectual Disability. -The use of restrictive interventions was not documented as a planned intervention. -No documentation of orders for restrictive interventions between 3/22/23 and 4/6/23. -No documentation client #1 had been assessed by a responsible professional following restrictive interventions between 3/22/23 and 4/6/23. Refer to V521 for documentation of 6 restrictive interventions between 3/22/23 and 4/6/23. Finding #2: Review on 4/5/23 of current #2's record revealed: -17 year old male admitted to the facility on 3/20/23. -Diagnoses included ADHD, Conduct Disorder, and Post Traumatic Stress Disorder (PTSD). -The use of restrictive interventions was not documented as a planned intervention. -No documentation of orders for restrictive interventions on 3/30/23 or 4/4/23. -No documentation client #2 had been assessed by a responsible professional following restrictive interventions on 3/30/23 or 4/4/23. Refer to V521 for documentation of restrictive interventions on 3/30/23 and 4/4/23.	V 522		

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V 522	Continued From page 57 Finding #3: Review on 4/4/23 and 4/12/23 of client #10's record revealed: -17 year old male admitted to the facility on 4/2/23. -Diagnoses included Conduct Disorder, Disruptive Mood Dysregulation Disorder (DMDD), and Major Depressive Disorder. -The use of restrictive interventions was not documented as a planned intervention. -No documentation of orders for restrictive interventions on 4/4/23. -No documentation client #10 had been assessed by a responsible professional following restrictive interventions on 4/4/23. Refer to V521 for documentation of restrictive intervention on 4/4/23. Review on 4/5/23 of the facility restrictive intervention policy dated 10/8/2018 revealed: -The policy did not identify the person who would be responsible to conduct an assessment of a client following a restrictive intervention. -The policy did not include a procedure to obtain orders for restrictive interventions. Interview on 4/4/23 staff #1 stated: -If a client tried to hurt himself or others staff would put them in a "CPI" (Crisis Prevention Institute) hold. -The nurse or someone else would come to the facility to evaluate a client only if the client had been hurt. -The staff documented injuries using a form that had a diagram of a body; if injured staff would check on the client every hour and document. Interview on 4/5/23 the Lead Qualified	V 522		

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V 524	Continued From page 59 renewed for up to a total of 24 hours in accordance with the limits specified in Item (E) of Subparagraph (e)(10) of this Rule. (14) Standing orders or PRN orders shall not be used to authorize the use of seclusion, physical restraint or isolation timeout. (15) The use of a restrictive intervention shall be considered a restriction of the client's rights as specified in G.S. 122C-62(b) or (d). The documentation requirements in this Rule shall satisfy the requirements specified in G.S. 122C-62(e) for rights restrictions. (16) When any restrictive intervention is utilized for a client, notification of others shall occur as follows: (A) those to be notified as soon as possible but within 24 hours of the next working day, to include: (i) the treatment or habilitation team, or its designee, after each use of the intervention; and (ii) a designee of the governing body; and (B) the legally responsible person of a minor client or an incompetent adult client shall be notified immediately unless she/he has requested not to be notified. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the guardian immediately following a restrictive intervention or members of the treatment team affecting 6 of 7 clients audited (clients #1, #2, #6, #7, #9, #10). The findings are: Refer to V521 for record reviews for clients #1, #2, #6, #7, #9, and #10, who had restrictive interventions documented on facility incident reports or North Carolina Incident Response and Improvement System (IRIS) reports.	V 524	V524: The facility will ensure QP's to notify the guardian immediately following a restrictive intervention or members of the treatment. The QP's will monitor as needed. Lead QP will monitor daily.	May 4, 2023

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V 524	Continued From page 60 Interviews on 4/13/23 with the guardians of client #1, client #2, client #6, client #9, and client #10 revealed they had not been notified since admission of any restrictive interventions. Attempted interview on 4/13/23 with client #7's guardian was unsuccessful. Interview on 4/5/23 the Lead Qualified Professional stated: -Information about restrictive interventions was not documented in a client's record. -She would be notified if a restrictive intervention was used. -Guardians were not called for all restrictive interventions, This deficiency is cross-referenced into 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS(Tag V109) for a Standard Deficiency rule violation and must be corrected within 30 days.	V 524		
V 525	27E .0104(e17) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (17) The facility shall conduct reviews and reports on any and all use of restrictive interventions, including: (A) a regular review by a designee of the governing body, and review by the Client Rights Committee, in compliance with confidentiality	V 525		

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V 525	Continued From page 61 rules as specified in 10A NCAC 28A; (B) an investigation of any unusual or possibly unwarranted patterns of utilization; and (C) documentation of the following shall be maintained on a log: (i) name of the client; (ii) name of the responsible professional; (iii) date of each intervention; (iv) time of each intervention; (v) type of intervention; (vi) duration of each intervention; (vii) reason for use of the intervention; (viii) positive and less restrictive alternatives that were used or that were considered but not used and why those alternatives were not used; (ix) debriefing and planning conducted with the client, legally responsible person, if applicable, and staff, as specified in Parts (e)(9)(F) and (G) of this Rule, to eliminate or reduce the probability of the future use of restrictive interventions; and (x) negative effects of the restrictive intervention, if any, on the physical and psychological well-being of the client. This Rule is not met as evidenced by: Based on interviews, the facility failed maintain a restrictive intervention log. The findings are: Interview on 4/5/23 the Lead Qualified Professional (QP) stated she had not thought to develop a log to record restrictive interventions. Interview on 4/13/23 the Director stated: -There had been a restrictive intervention log in the past. -She would "estimate" it was in place before August of 2022. -The log was stopped for "no particular reason." -She had been absent from work for medical	V 525	V525: The facility will ensure to maintain a restrictive intervention log. This will be monitored by Lead QP daily.	June 3, 2023

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V 525	Continued From page 62 reasons and when she returned the log was no longer in place.	V 525		
V 526	27E .0104(e18-19) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (18) The facility shall collect and analyze data on the use of seclusion and physical restraint. The data collected and analyzed shall reflect for each incident: (A) the type of procedure used and the length of time employed; (B) alternatives considered or employed; and (C) the effectiveness of the procedure or alternative employed. The facility shall analyze the data on at least a quarterly basis to monitor effectiveness, determine trends and take corrective action where necessary. The facility shall make the data available to the Secretary upon request. (19) Nothing in this Rule shall be interpreted to prohibit the use of voluntary restrictive interventions at the client's request; however, the procedures in this Rule shall apply with the exception of Subparagraph (f)(3) of this Rule. This Rule is not met as evidenced by: Based on interview, the facility failed to collect and analyze data as required for the use of seclusion and physical restraints. The findings are:	V 526	V526: The facility will ensure collecting and analyzing data as required for the use of seclusion and physical restraints. This will be monitored by Licensed Professional weekly.	June 3, 2023

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V 526	Continued From page 63 Interview on 4/13/23 the Director stated: -In the past there was a Human Rights Committee that met quarterly. -Instead of the quarterly Human Rights Committee meeting, there was now a weekly meeting. -The Director was responsible for these weekly meetings. -In addition to herself, the members of the weekly committee were the Physician Licensee, Educator, the facility Licensed Professional, Lead Qualified Professional, and the Human Resources Director. -The committee reviewed all incident reports. -There was no way to analyze and look at restrictive intervention trends. -There had been a restrictive intervention log in the past, but it had been discontinued.	V 526		
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 observations and interview the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are:	V 736	V736: The facility will ensure a safe, clean, attractive, and orderly environment. This will be monitored by QP's daily, Lead QP's weekly, Residential Director weekly and Maintenance weekly.	June 3, 2023

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V 736	Continued From page 64 Observation of the facility on 4/4/23 at approximately 10:45am revealed: -The ceiling vent in bathroom #1 was rusted. The faucet assembly in the shower was loose to the touch and not secured to the wall. -The bedroom door handle to room #6 was loose to the touch and there was a 1" section of the door approximately 24" in length that was missing under the door knob. -Room #5 had a dusty ceiling vent. -Three of the 8 fluorescent ceiling lights were not working in the common area. -A section of drywall approximately 20" in length was missing around the window frame in the common area, exposing the metal frame beneath. -The facility's rear siding had exposed sharp edges and discolored stains. -There was no outlet cover on rear outlet at the back of the facility, exposing junction wires. During interview on 4/13/23 the Director stated she would address the concerns.	V 736		
V 752	27G .0304(b)(4) Hot Water Temperatures 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit. This Rule is not met as evidenced by:	V 752		

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RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(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 752	Continued From page 65 Based on observation and interview, the facility water temperatures were not maintained between 100-116 degrees Fahrenheit in areas where clients were exposed to hot water. The findings are: Observation on 4/4/23 at approximately 10:45am revealed: -The hot water temperature in bathroom #1 was 126 degrees Fahrenheit at the sink and 119 degrees Fahrenheit in the shower. -The hot water temperature in bathroom #2 was 124 degrees Fahrenheit at the sink and in the shower. -The hot water temperature in bathroom #3 was 124 degrees Fahrenheit at the sink and 120 degrees Fahrenheit in the shower. Interview on 4/4/23 the Maintenance Technician stated: -He had tested the water temperatures approximately 2 weeks earlier at the kitchen sink and the temperature was 101. -He maintained a log to monitor changes in temperature but did not have a reference to determine where the proper setting on the hot water needed to be. -He would work to ensure temperature was maintained at proper temperature range This deficiency has been cited four times since the original cite on 2/02/22 and must be corrected within 30 days.	V 752	V752: The facility will ensure water temperatures are maintained between 100-116 degrees Fahrenheit in areas where clients are exposed to hot water. This will be monitored daily by the Facility Manager and QP's. Lead QP's and Maintenance will monitor weekly. The Residential Director will monitor monthly.	May 4, 2023

THE CARTERCLINIC
CONTINUING A LEGACY OF EXCELLENCE IN BEHAVIORAL HEALTH

May 11, 2023

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Re: Complaint Survey completed April 13, 2023
Renewing Grace Residential Home, 703 West 3rd Ave., Building A, Red Springs, NC 2877
MHL# 078-325

To Whom It May Concern:

Enclosed you will find corrections of the deficiencies cited listed on the Statement of Deficiencies Form.

If you have any questions, please contact our office at (910) 491-2352 or mobile phone (910) 978-3675 or email: asia_parker@yahoo.com or Melody Thomas, Residential Director at (910) 491-2352 or mobile (910) 813-7968 or email: thomasmelody@rocketmail.com

Sincerely,

Asia Locklear, QP

Asia Locklear
Lead Qualified Professional