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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL0601430	B. WING		07/12/2023	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7827 KERRYBROOK CIRCLE CHARLOTTE, NC 28214						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
∨ 000	One complaint was un (NC00202243) and on (NC00202720). Deficing this facility is licensed category: 10A NCAC Treatment Staff Secur Adolescents. This facility is licensed.	ne was substantiated iencies were cited. d for the following service 27G 1700 Residential re for Children or d for four and currently has survey sample consisted of	V 000	RECEIVED By Laura Bryant at 3:50 p	om, Jul 20, 2023	
V 293	10A NCAC 27G .170 (a) A residential treat children or adolescen free-standing resident intensive, active there interventions within a shall not be the prima who is not a client of the bystaff secure mean awake during client shall be continuous at this Section. (c) The population set adolescents who have mental illness, emotion substance-related disco-occurring disordered disabilities. These chand made the criteria for intervention of the children or ac require the following:	ment staff secure facility for the is one that is a stall facility that provides appeutic treatment and system of care approach. It ry residence of an individual the facility. In a staff are required to be eep hours and supervision as set forth in Rule .1704 of the reved shall be children or a primary diagnosis of anal disturbance or orders; and may also have as including developmental ildren or adolescents shall apatient psychiatric services.	V 293			

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

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL0601430	B. WING		07/12	2/2023	
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
MIRACLE	HOUSES KERRYBROOM	K CIRCLE	RYBROOK CIR ITE, NC 28214	CLE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 293	facilitate treatment; a (2) treatment ir (e) Services shall be (1) include indistructure of daily livin (2) minimize the related to functional of (3) ensure safe control behaviors inclumanagement with or (4) assist the concurrence of adaptive communication, social of the social stream of the shall coordinate with agencies within the confidence of care. This Rule is not met Based on interviews a facility failed to ensure other individuals and treatment, effecting of the stall continuation.	nd a staff secure setting. designed to: vidualized supervision and g; e occurrence of behaviors deficits; ety and deescalate out of uding frequent crisis without physical restraint; hild or adolescent in the e functioning in self-control, al and recreational skills; and child or adolescent in ded to step-down to a less etting. eatment staff secure facility other individuals and hild or adolescent's system	V 293	27G.1701 Correct: Youth was seen by a second therapi will provide documentation of sessio occurred. During the staff meeting, staff will be reminded of their role to support the and have them participate in therapy Staff reviewed the Therapy Schedule each youth. Prevent: Miracle House has identified a secontherapist who will be available to suptherapy needs if a youth. At the end shift, staff members will document the refusal on the shift note and notify the Social Worker. Monitor: During weekly meetings, the QP will how many youth have refused Thera discuss with the Therapist strategies improve participation.	child	7.22.23	
		FC#1's record revealed: 3 and discharged 5-11-23.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL0601430	B. WING		07	//12/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MIRACLE	HOUSES KERRYBROOK	(CIRCLE	RYBROOK CIR TTE, NC 28214	CLE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 293	Disorder, Conduct Disand Stressor Related -Screening Asses 23 revealed: Current stealing, verbal aggredestructionGoals include: noverbal and physical and physical and authority figures. Review on 6-5-23 of Inappointments revealed and physical and physical and authority figures. Review on 6-5-23 of Inappointments revealed appointments revealed appointment for appointment for a steady and a steady and a steady appointment for a steady appo	de: Attention Deficit sorder, Unspecified Trauma Disorder. ssment completed on 1-25- problems include, lying, ession and property ot instigating conflict, reduce ggression, and listen to FC#1's therapy ed: y appointments were -16-235-10-23. eents were either no show or with FC#1's therapist e (of therapy visits) was an are coming to my office. She missing the bus and staff le her so like she would If to call family. One instance (absent without leave)so We only had 6 sessions over e issues."	V 293			
	-If someone miss					

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DIVISION	n rieaith Service Negu	ialion				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
MHL0601430		B. WING		07/4	0/0000	
		WITL0601430			07/1	2/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MD 4 61 E	HOUGES KERRYRRS	7827 KERF	YBROOK CIR	CLE		
MIRACLE	HOUSES KERRYBROOM	CHARLOT	TE, NC 28214			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	٧	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				,		
V 293	Continued From page	e 3	V 293			
	with another therenies	•				
	with another therapis	L.				
\ / 500	075 0400 011 4 51 4		1,4500			
V 539	27F .0102 Client Righ	nts - Living Environment	V 539	27F.0102		
	40 A NO A O 07E 0400) INVINC				
	10A NCAC 27F .0102 ENVIRONMENT	2 LIVING		Correct:		
		ha pravidadi		Staff members reviewed the Therapy appointments for each youth. Therapy will		
	(a) Each client shall	•				7.22.23
	. ,	ere conducive to		be conducted at the Therapists office	Э.	7.22.20
		uring scheduled sleeping				
		the types of services being		If the youth cannot travel to the Ther		
		e of clients being served; and		office, there is a dedicated device fo	r youth	
		areas for personal privacy,		to complete their Therapy.		
	for at least limited per			Bassasta		
		iate by the treatment or		Prevent:		
	habilitation team.	ha fraa ta ayitahly dagarata				
		be free to suitably decorate		If youth are participating in Therapy	via	
		on of a multi-resident room,		Zoom, staff members will designate		
	=	e, normalization principles,		area for Therapy that is quiet and fre		
	•	he physical structure. Any		distraction. Staff members will also a		
		edom shall be carried out in		youth who are interrupting Therapy		
	accordance with gove	erning body policy.		sessions.		
				Monitor:		
	This Dula is not mot	as avidenced by:		During weekly meetings, the QP will		
	This Rule is not met	<u> </u>		how many youth have refused Thera		
		the facility failed to ensure		discuss with the Therapist strategies	to	
		vacy, effecting one of one		improve participation.		
	former client (Former	Client #1). The findings are:				
	Interview on 6-1-23 w	vith EC#1 revealed:				
	room where she was	ould frequently come into the				
		on her can with her				
	therapist.	la au con a tha in mharrar farr				
		her use their phone for				
therapy, but then would come into the		iid come into the room and				
	want it back.					
		:: O:: 1/10				
	Interview on 6-29-23	with Client #2 revealed:				

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		MHL0601430	B. WING		07	/12/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ΓE, ZIP CODE		
MIRACLE	HOUSES KERRYBROOM	K CIRCLE	RRYBROOK CIR TTE, NC 28214	CLE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
V 539	a staff phone. -The Qualified Proom and watch her was revealed: -She didn't think phone the clients couwould use the staff's -Staff would freq -Staff or another something or ask quefrequent activity. -"I said we need Interview on 5-31-23 (FC#1) Social Work (Control of the staff would not her therapy. -They would let come and talk with FC talk with her therapist Interview on 5-12-23 -The clients now for therapy.	rofessional will sit in the when she has therapy. with FC#1's therapist the facility had a designated old use for therapy, so they phone. uently interrupt. client would come in to grab estions. There would be to have in person sessions." with Former Client #1's Guardian revealed: protect FC#1's privacy during other people come into the C#1 when she was trying to the therapists' office with the Director revealed: go to the therapists' office	V 539			

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