

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL071-022</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/10/2023</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>A SPECIAL TOUCH, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5925 NC HIGHWAY 11 WILLARD, NC 28478</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

V 000	INITIAL COMMENTS  An annual survey was completed on May 10, 2023. Deficiencies were cited.  This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.  This facility is licensed for 4 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.	V 000	<u>See Attached</u>	
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan  10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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

5/16/23 (X6) DATE

TITLE  
*Susie Hayes, Esq Director*

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL071-022</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/10/2023</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>A SPECIAL TOUCH, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5925 NC HIGHWAY 11 WILLARD, NC 28478</b>
---	--

(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 112	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement goals and strategies based on client assessment for 1 of 3 clients (client #1). The findings are:</p> <p>Review on 5/8/23 and 5/9/23 of client #1's record revealed: -16 year old male admitted on 10/11/22. -Diagnoses included disruptive mood dysregulation disorder (DMDD) and attention deficit hyperactivity disorder. -Admission assessment dated 10/22/22 documented presenting problems to be aggression, suicidal ideation, problems in the school setting, school suspensions, aggression within the home towards his younger brother, and several involuntary commitments recently.</p> <p>Review on 5/9/23 of client #'s Psychological Examination dated 1/16/23 revealed: -History of 4-5 suicide attempts since 2015. -Client #1 continued to verbalize suicidal and homicidal ideations. -Recommendations included residential services to develop skills for activities of daily living, independent living skills, social functioning, and to "ensure/monitor safety."</p> <p>Review on 5/9/23 of client #1's Comprehensive Clinical Assessment dated 10/26/22 revealed:</p>	V 112	<p style="text-align: center; font-size: 2em;"><u>See Attached</u></p>	
-------	---	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL071-022</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/10/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>A SPECIAL TOUCH, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5925 NC HIGHWAY 11 WILLARD, NC 28478</b>
---	--

(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 112	<p>Continued From page 2</p> <p>-4-5 suicidal attempts since 2015 including use of belts, shoe laces, ace bandages, and most recent (June 2020) putting a knife to his chest, trying to jump from a 2 story window, and riding his bike in front of a car.</p> <p>-January 2021 client became physically aggressive toward his mother and sister and made statements, "I'm going to kill myself."</p> <p>-March 2021 client #1 was physically aggressive toward his younger brother and was admitted to a mental health facility for 10 days. "Client continues to verbalize suicidal ideations such as 'I just want to die,' 'life isn't worth it,' 'this is why people like me kill themselves.'" Homicidal ideations were also verbalized.</p> <p>-Note dated 10/24/22, "Client reported struggling with 'anger' ...feeling down, worry about school and home.' .. reported he has not had thoughts of hurting himself or others in a 'long time' approximately a month .... Per group home staff client had not exhibited any aggressive or self harm behaviors, but had engaged in some verbal altercations with a peer."</p> <p>Review on 5/9/23 of client #1's treatment plan revealed:</p> <p>-There were no goals or strategies for client safety regarding self harm, suicidal ideations or homicidal ideations.</p> <p>Interview on 5/8/23 client #1 stated:</p> <p>-He had been in the facility since September or October of 2022.</p> <p>-He thinks it is helping him to be in the facility.</p> <p>-He has more self control since being in the facility.</p> <p>Interview on 5/9/23 direct care staff #2 stated he was not aware of any current client with a history of suicidal attempts.</p>	V 112	<p style="font-size: 2em; text-align: center;"><u>See Attached</u></p>	
-------	---	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL071-022</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/10/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>A SPECIAL TOUCH, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5925 NC HIGHWAY 11 WILLARD, NC 28478</b>
---	--

(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 112	<p>Continued From page 3</p> <p>Interview on 5/10/23 direct care staff #6 stated he was not aware of any current client with a history of suicidal attempts.</p> <p>Interview in 5/8/23 the Qualified Professional stated: -He was aware client #2 had a history reported of suicide attempts. -Client #1 had not demonstrated any suicidal ideations since his admission. -The facility always kept knives secured so that clients did not have access. -Staff were made aware of client needs and goals before they were admilted.</p>	V 112		
V 118	<p>27G .0209 (C) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name;</p>	V 118	<p><i>See Attached</i></p> <hr/>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL071-022</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/10/2023</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>A SPECIAL TOUCH, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5925 NC HIGHWAY 11 WILLARD, NC 28478</b>
---	--

(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 118	<p>Continued From page 4</p> <p>(B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to administer medications as ordered and maintain a current MAR for 1 of 3 clients (#1). The findings are:</p> <p>Review on 5/8/23 and 5/9/23 of client #1's record revealed: -16 year old male admitted on 10/11/22. -Diagnoses included disruptive mood dysregulation disorder (DMDD) and attention deficit hyperactivity disorder (ADHD).</p> <p>Review on 5/8/23 and 5/9/23 of client #1's orders/dates revealed: -12/12/22 order: -Lithium Carbonate 300 mg (milligrams) TID (3 times daily). (mood stabilizing medication) -Lithium Carbonate 600 mg at bedtime. -1/12/23 order: -Starting 1/26/23, Lithium Carbonate 300 mg BID (2 times daily). -Starting 2/26/23, Lithium Carbonate 300 mg once daily.</p>	V 118	<p><u>See Attached</u></p>	
-------	--	-------	----------------------------	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL071-022</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/10/2023</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>A SPECIAL TOUCH, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5925 NC HIGHWAY 11 WILLARD, NC 28478</b>
---	--

(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 118	<p>Continued From page 5</p> <ul style="list-style-type: none"> <li>-Discontinue Lithium Carbonate 3/23/23.</li> <li>-Lamotrigine 25 mg once daily. (mood stabilizing medication)</li> <li>-Starting 2/9/23 start Lamotrigine 25 mg BID.</li> <li>-Starting 3/9/23 start Lamotrigine 100 mg daily.</li> <li>-2/21/23 order: Fluoxetine 20 mg in the morning. (major depressive disorder)</li> <li>-3/14/23 order: Fluoxetine 10 mg daily with 20 mg capsule.</li> <li>-4/11/23 order: Fluoxetine 20 mg to be given in the evening.</li> <li>-10/11/22 order: Vit D3 1250 mcg (micrograms) every 7 days. (supplement)</li> <li>-11/16/22 order: Vit D2 1250 mcg every 7 days.</li> </ul> <p>Review on 5/8/23 and 5/9/23 of client #1's MARs from January 2023 - May 2023 revealed:</p> <ul style="list-style-type: none"> <li>-MARs were formatted as a continuous log of documented dosing. The order for the medication was not transcribed to each ongoing page, and the transcribed order was not updated as orders changed.</li> <li>-The transcribed orders for Lithium Carbonate read to administer 300 mg capsules, 1 capsule 3 times daily and 2 capsules every night at bedtime.</li> <li>-Reminder notes had been affixed to the Lithium Carbonate MAR that read, "Take this med in the mornings only 22323."</li> <li>-The time to change dosing times for Fluoxetine from morning to evening were written on a removable note on the MAR rather than the order transcribed to the MAR.</li> <li>-Vit D3 1250 mcg every 7 days was documented for the months of January and February.</li> </ul> <p>Interview on 5/9/23 the Licensee stated:</p> <ul style="list-style-type: none"> <li>-She had been very careful to make sure client #1's taper orders had been given correctly.</li> <li>-She did not start a new MAR log each time an</li> </ul>	V 118	<p><i>See Attached</i></p> <hr style="width: 20%; margin: auto;"/>	
-------	---	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL071-022</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/10/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>A SPECIAL TOUCH, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5925 NC HIGHWAY 11 WILLARD, NC 28478</b>
---	--

(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 118	<p>Continued From page 6</p> <p>order changed; she would put notes on the MAR to remind staff to give according to the new order. -She did not have an order for Vitamin D2 until she requested one from the pharmacy on 5/9/23. -She was not aware the doctor had written for Vitamin D2 on 11/16/22 when the client was seen for a physical exam.</p> <p>Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician.</p>	V 118	<p style="font-size: 2em; text-align: center;"><i>See Attached</i></p> <hr style="width: 20%; margin: auto;"/>	
V 131	<p>G.S. 131E-256 (D2) HCPR - Prior Employment Verification</p> <p>G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to access the Health Care Personnel Registry (HCPR) prior to hire for 2 of 3 audited staff (#4, #6). The findings are:</p> <p>Finding #1: Review on 5/10/23 of Staff #4's personnel record revealed:</p>	V 131		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL071-022</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/10/2023</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>A SPECIAL TOUCH, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5925 NC HIGHWAY 11 WILLARD, NC 28478</b>
---	--

(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 131	<p>Continued From page 7</p> <p>-Hire date: 2/22/22. -Position: Residential Counselor. -The HCPR was accessed on 3/15/22. -Staff #4 had been involuntarily terminated from his prior employment with the facility on 7/11/21.</p> <p>Interview on 5/8/23 Staff #4 stated: -He had worked with the facility for 4 years.</p> <p>Finding #2: Review on 5/10/23 of Staff #6's personnel record revealed: -Hire date: 4/26/22. -Position: Residential Counselor -The HCPR was accessed on 5/17/22.</p> <p>Interview on 5/10/23 Staff #6 stated: -He had worked with the facility about 1 year.</p> <p>Interview on 5/10/23 the Licensee stated: -She did not think Staff #4 had been deleted from the payroll system. -There were no other HCPR checks prior to hire for Staff #4 and #6.</p>	V 131	<p><i>See Attached</i></p>	
V 133	<p>G.S. 122C-80 Criminal History Record Check</p> <p>G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT. (a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. (b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the</p>	V 133		



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL071-022</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/10/2023</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>A SPECIAL TOUCH, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5925 NC HIGHWAY 11 WILLARD, NC 28478</b>
---	--

(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 133	<p>Continued From page 8</p> <p>applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history</p>	V 133	<p><i>See Attached</i></p> <hr style="width: 20%; margin: auto;"/>	
-------	--	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL071-022</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/10/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>A SPECIAL TOUCH, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5925 NC HIGHWAY 11 WILLARD, NC 28478</b>
---	--

(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 133	<p>Continued From page 9</p> <p>check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency.</p> <p>(c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant:</p> <ol style="list-style-type: none"> <li>(1) The level and seriousness of the crime.</li> <li>(2) The date of the crime.</li> <li>(3) The age of the person at the time of the conviction.</li> <li>(4) The circumstances surrounding the commission of the crime, if known.</li> <li>(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.</li> <li>(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.</li> <li>(7) The subsequent commission by the person of a relevant offense.</li> </ol>	V 133	<p><i>See Attached</i></p>	
-------	---	-------	----------------------------	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL071-022</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/10/2023</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>A SPECIAL TOUCH, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5925 NC HIGHWAY 11 WILLARD, NC 28478</b>
---	--

(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 133	<p>Continued From page 10</p> <p>The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.</p> <p>(d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for:</p> <p>(1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual.</p> <p>(2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section.</p> <p>(e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendary Device or Material; Article 14, Burglary</p>	V 133	<p><i>See Attached</i></p> <hr style="width: 100px; margin: auto;"/>	
-------	--	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL071-022</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/10/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>A SPECIAL TOUCH, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5925 NC HIGHWAY 11 WILLARD, NC 28478</b>
---	--

(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 133	<p>Continued From page 11</p> <p>and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.</p> <p>(f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor.</p> <p>(g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met:</p> <p>(1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in</p>	V 133	<p><i>See Attached</i></p> <hr/>	
-------	---	-------	----------------------------------	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL071-022</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/10/2023</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>A SPECIAL TOUCH, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5925 NC HIGHWAY 11 WILLARD, NC 28478</b>
---	--

(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 133	<p>Continued From page 12</p> <p>subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10. (2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.)</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to conduct a criminal history record check as required for 1 of 3 audited staff (Staff #4). The findings are:</p> <p>Review on 5/10/23 of Staff #4's personnel record revealed: -Hire date: 2/22/22. -Position: Residential Counselor. -Criminal background check dated 1/21/18. -Staff #4 had been involuntarily terminated from his prior employment with the facility on 7/11/21.</p> <p>Interview on 5/8/23 Staff #4 stated: -He had worked with the facility for 4 years.</p> <p>Interview on 5/10/23 the Licensee stated: -She did not think Staff #4 had been deleted from the payroll system. -There was no criminal background check for Staff #4 other than the one dated 1/21/18.</p>	V 133	<p><i>See Attached</i></p> <hr style="width: 20%; margin: auto;"/>	
V 318	130 .0102 HCPR - 24 Hour Reporting	V 318		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL071-022</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/10/2023</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>A SPECIAL TOUCH, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5925 NC HIGHWAY 11 WILLARD, NC 28478</b>
---	--

(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)	(X6) COMPLETE DATE
--------------------	--	---------------	---	--------------------

V 318	<p>Continued From page 13</p> <p><b>10A NCAC 130 .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL</b> The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g).</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report all allegations against health care personnel within 24 hours of the health care facility becoming aware of the allegation. The findings are:</p> <p>Review on 5/10/23 of Staff #6's record revealed: -Hired 4/26/22. -Position: Residential Counselor.</p> <p>Review on 5/8/23 of client #1's record revealed: -16 year old male admitted 10/11/22. -Diagnoses included disruptive mood dysregulation disorder and attention deficit hyperactive disorder.</p> <p>Review on 5/8/23 of client #1's North Carolina Incident Response and Improvement System (IRIS) reports during his admission to the facility</p>	V 318	<p><i>See Attached</i></p> <hr/>	
-------	---	-------	----------------------------------	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL071-022</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/10/2023</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>A SPECIAL TOUCH, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5925 NC HIGHWAY 11 WILLARD, NC 28478</b>
---	--

(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 318	<p>Continued From page 14</p> <p>revealed: -Incident occurred on 4/2/23 at 1:30 pm. -The provider was aware of the incident on 4/2/23. -The IRIS report was originally submitted 4/6/23 and last submitted on 4/11/23. -Client #1 reported Staff #6 chased him with a knife. -The report of Staff #6 to the HCPR was done via the IRIS report by the Licensee.</p> <p>Interview 5/9/22 the Licensee stated: -A report was not made to the the HCPR initially because she did not see the client's allegation as abuse. -The client changed his story several times. -The HCPR report was made in response to a communication from the Local Management Entity/Managed Care Organization via IRIS.</p>	V 318	<p><i>See Attached</i></p> <hr/>	
V 367	<p>27G .0604 Incident Reporting Requirements</p> <p>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</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL071-022</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/10/2023</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>A SPECIAL TOUCH, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5925 NC HIGHWAY 11 WILLARD, NC 28478</b>
---	--

(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 367	<p>Continued From page 15</p> <p>Information:</p> <p>(1) reporting provider contact and identification information;</p> <p>(2) client identification information;</p> <p>(3) type of incident;</p> <p>(4) description of incident;</p> <p>(5) status of the effort to determine the cause of the incident; and</p> <p>(6) other individuals or authorities notified or responding.</p> <p>(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:</p> <p>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or</p> <p>(2) the provider obtains information required on the incident form that was previously unavailable.</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(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</p>	V 367	<p><u>See Attached</u></p>	
-------	--	-------	----------------------------	--



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL071-022</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/10/2023</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>A SPECIAL TOUCH, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5925 NC HIGHWAY 11 WILLARD, NC 28478</b>
---	--

(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 367	<p>Continued From page 16</p> <p>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:</p> <ol style="list-style-type: none"> <li>(1) medication errors that do not meet the definition of a level II or level III incident;</li> <li>(2) restrictive interventions that do not meet the definition of a level II or level III incident;</li> <li>(3) searches of a client or his living area;</li> <li>(4) seizures of client property or property in the possession of a client;</li> <li>(5) the total number of level II and level III incidents that occurred; and</li> <li>(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.</li> </ol> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report all level II and III incidents within 72 hours of becoming aware of the incident. The findings are:</p> <p>Review on 5/10/23 of Staff #6's record revealed: -Hired 4/26/22. -Position: Residential Counselor.</p>	V 367	<p><i>See Attached</i></p> <hr style="width: 100px; margin: auto;"/>	
-------	---	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL071-022</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/10/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>A SPECIAL TOUCH, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5925 NC HIGHWAY 11 WILLARD, NC 28478</b>
---	--

(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 367	<p>Continued From page 17</p> <p>Review on 5/8/23 of client #1's record revealed: -16 year old male admitted 10/11/22. -Diagnoses Included disruptive mood dysregulation disorder and attention deficit hyperactive disorder.</p> <p>Review on 5/8/23 of client #1's North Carolina Incident Response and Improvement System (IRIS) reports during his admission to the facility revealed: -Incident occurred on 4/2/23 at 1:30 pm. -The provider was aware of the incident on 4/2/23. -The IRIS report was originally submitted 4/6/23 and last submitted on 4/11/23. -Client #1 reported Staff #6 chased him with a knife.</p> <p>Interview on 5/9/23 the Licensee stated: -She had not viewed the client #1's reports about Staff #6 to be allegations of abuse initially. -The client's story changed several times.</p>	V 367	<p><i>See Attached</i></p> <hr/>	
V 500	<p>27D .0101(a-e) Client Rights - Policy on Rights</p> <p>10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are</p>	V 500		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL071-022</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/10/2023</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>A SPECIAL TOUCH, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5925 NC HIGHWAY 11 WILLARD, NC 28478</b>
---	--

(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 500	<p>Continued From page 18</p> <p>instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications.</p> <p>(c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies:</p> <p>(1) any restrictive intervention that is prohibited from use within the facility; and</p> <p>(2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client.</p> <p>(d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify:</p> <p>(1) the permitted restrictive interventions or allowed restrictions;</p> <p>(2) the individual responsible for informing the client; and</p> <p>(3) the due process procedures for an involuntary client who refuses the use of restrictive interventions.</p> <p>(e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes:</p> <p>(1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E);</p>	V 500	<p><i>See Attached</i></p> <hr style="width: 100px; margin: auto;"/>	
-------	--	-------	--	--

Division of Health Service Regulation

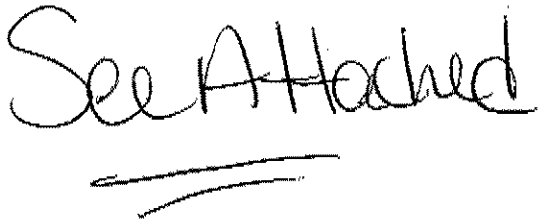
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL071-022</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/10/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>A SPECIAL TOUCH, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5925 NC HIGHWAY 11 WILLARD, NC 28478</b>
---	--

(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 500	<p>Continued From page 19</p> <p>(2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and</p> <p>(3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report all instances of alleged or suspected abuse, neglect or exploitation of clients to the County Department of Social Services (DSS) as required. The findings are:</p> <p>Review on 5/10/23 of Staff #6's record revealed: -Hired 4/26/22. -Position: Residential Counselor</p> <p>Review on 5/8/23 of client #1's record revealed: -16 year old male admitted 10/11/22. -Diagnoses included disruptive mood dysregulation disorder and attention deficit hyperactive disorder.</p> <p>Review on 5/8/23 of client #1's North Carolina Incident Response and Improvement System (IRIS) reports during his admission to the facility revealed: -Incident occurred on 4/2/23 at 1:30 pm. -Client #1 reported Staff #6 chased him with a knife. -The provider was aware of the incident on 4/2/23. -The IRIS report was originally submitted 4/6/23 and last submitted on 4/11/23. -The IRIS report was a level III. -There was no documentation the incident was</p>	V 500	<p><i>See Attached</i></p>	
-------	---	-------	----------------------------	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL071-022</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/10/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>A SPECIAL TOUCH, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>5925 NC HIGHWAY 11 WILLARD, NC 28478</b>		
(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)	(X6) COMPLETE DATE
V 500	Continued From page 20 reported to the county DSS.  Interview 5/9/22 the Licensee stated: -The incident had not been reported to DSS. -The Licensee was not aware of this requirement to report to DSS.	V 500	<p><i>See Attached</i></p> 	

A Special Touch, Inc.  
5925 NC Hwy 11  
Willard, NC 28478

**V 112 27G.0205 (C-D) ASSESSMENT/TREATMENT/HABILITATIOIN PLAN**

**PLAN OF CORRECTION**

A Special Touch, Inc. recognizes that suicides are a public health problem that can have a lasting harmful effect on individuals, families, and community. This is why A Special Touch, Inc. is a strong supporter of all suicide programs and trainings.

A Special Touch, Inc. shall participate in the preparation of the consumer's Assessment as needed.

A Special Touch, Inc. shall review the Assessment and check to see if there is any diagnosis which reference suicidal ideations, suicide attempts, and verbalize homicide ideations.

A Special Touch, Inc. shall meet with all individuals which are associated with the consumer in the preparation of the Person-Centered Plan.

A Special Touch, Inc. shall include a goal and strategies in the consumer's Person-Centered Plan that will reference all suicidal issues.

A Special Touch, Inc. shall review with the consumer, family, and guardians at the consumer's monthly meeting about his goals and strategies.

A Special Touch, Inc. shall make available the **SUICIDE HOT LINE** on the bulletin board in the facility. (National Suicide Prevention Lifeline) **800-273-8725**

**PREVENTION OF PROBLEM**

A Special Touch, Inc. will engage in the reading and understanding of the Assessment and the preparation of the PCP of each client.

**MONITOR OF THE SITUATION**

A Special Touch, Inc. Qualified Professional shall be the monitor by becoming knowledgeable of the client's Assessment and when preparing the client PCP.

**MONITORING TIME FRAME**

A Special Touch, Inc. QP shall monitor the timeframe preparation of clients Assessments and PCP at the initiation of these documents.

A Special Touch, Inc.  
5925 NC Hwy 11  
Willard, NC 28478

**V 118 27G.0209 (C) MEDICATION REQUIREMENTS**

**PLAN OF CORRECTION**

A Special Touch, Inc. shall ensure that all consumers are visited by a licensed medical professional authorized by law to receive a medical diagnosis and receive prescriptions and non-prescriptions.

A Special Touch, Inc. shall ensure that all consumers receiving medication shall have a current Medication Administration Record (MAR).

A Special Touch, Inc. shall ensure that the MAR contains consumer name, strength, quantity of drug, administration of the drug, date, time of drug being administered and the name or initial of the person administering the drug.

A Special Touch, Inc. shall ensure that any medications that have been discontinued shall be recorded, file and follow-up with the medical professional that prescribed the medications.

A Special Touch, Inc. shall always ensure that medications administered are documented on the MAR.

**PREVENTION OF PROBLEM**

A Special Touch, Inc. shall ensure that each client medication history and current medical health is being adhered to and by following the client medical provider instructions.

A Special Touch, Inc. shall follow the requirements of preparing the client's MAR by recording all medication consistently and correctly.

A Special Touch, Inc. shall conduct in-service training for all personnel on the requirements of the MAR.

**MONITOR OF THE SITUATION**

A Special Touch, Inc. Executive Director shall monitor the medication and MAR requirements.

**MONITORING TIME FRAME**

A Special Touch, Inc. shall conduct a review of all client's medications and MARs as needed.

A Special Touch, Inc.  
5925 NC Hwy 11  
Willard, NC 28478

**V 131 G.S.131E-256 (D2)-PRIOR PERSONNEL REGISTRY**

**PLAN OF CORRECTION**

A Special Touch, shall access the Health Care Personnel Registry (HCPR) prior to the employment of all personnel.

A Special Touch, Inc. shall contact the (HCPR) on all former personnel applying for rehire.

A Special Touch, Inc. shall not employ an applicant that appears negative on the (HCPR).

**PREVENTION OF PROBLEM**

A Special Touch, Inc. shall follow employment requirements by submitting the applied applicant information prior to possible employment to the HCPR for confirmation for employment.

**MONITOR OF THE SITUATION**

A Special Touch, Inc. Executive Director shall be responsible for monitoring and overseeing the employment requirements for employment.

**MONITORING TIME FRAME**

A Special Touch, Inc. time frame shall be initiated during the pre-employment review of the applied applicant.



A Special Touch, Inc.  
5925 NC Hwy 11  
Willard, NC 28478

**V 133 G.S 122C-80 -CRIMINAL HISTORY RECORD CHECK**

**PLAN OF CORRECTION**

A Special Touch, Inc. shall conduct a criminal background check on all applicants seeking employment and applicants that are rehired.

A Special Touch, Inc. will not offer a potential applicant with initial employment until after a criminal background check has been conducted and approved.

**PREVENTION OF PROBLEM**

A Special Touch, Inc. shall interview the applicant and decide if the applicant meet or exceeds the requirements for employment.

**MONITOR OF THE SITUATION**

A Special Touch, Inc. Executive Director shall monitor the complete employment process of all applicants.

**MONITORING TIME FRAME**

A Special Touch, Inc. timeframe is based on the employment requirements as met by the facility policy.

A Special Touch, Inc.  
5925 NC Hwy 11  
Willard, NC 28478

**V 318 130.0102 HCPR -24 Hour Reporting**

**PLAN OF CORRECTION**

A Special Touch, Inc. shall contact the local county Department of Social Services within 24 hours when an alleged abuse has been reported.

A Special Touch, Inc. shall submit the IRIS report of the allegation to the MCO within 72 hours of the allegation.

**PREVENTION OF PROBLEM**

A Special Touch, Inc. shall follow the standards as required when all types of abuse, neglect and exploitation has occurred.

**MONITOR OF THE SITUATION**

A Special Touch, Inc. Qualified Professional and Executive Director shall be responsible for monitoring.

**MONITORING TIME FRAME**

A Special Touch, Inc. personnel timeframe shall follow the reporting requirements to DSS and the MCO.

A Special Touch, Inc.  
5925 NC Hwy 11  
Willard, NC 28478

**V 367 27G.0604 – Incident Reporting Requirements**

**PLAN OF CORRECTION**

A Special Touch, Inc. shall submit all level II incidents within 72 hours when becoming aware of an allegation to the MCO.

A Special Touch, Inc. shall provide complete accurate information when preparing the 72-hour report to the MCO.

**A Special Touch, Inc. shall prepare and submit the quarterly incident report to the MCO when there have been not reportable incidents in accordance with the standards of this section.**

**PREVENTION OF PROBLEM**

A Special Touch, Inc. shall follow the requirements as referenced to required incidents and the reporting requirements.

**MONITOR OF THE SITUATION**

A Special Touch, Inc. Executive Director and Qualified Professional shall be responsible for all monitoring.

**MONITORING TIME FRAME**

A Special Touch, Inc. shall be responsible for monitoring timeframe based on the required reporting of incidents and reporting of required documents.

A Special Touch, Inc.  
5925 NC Hwy 11  
Willard, NC 28478

**V 500 27D.0101 (a-e) Client Rights-Policy on Rights**

**PLAN OF CORRECTION**

A Special Touch, Inc. shall adhere to the policy of this section and report all alleged or suspected abuse, neglect, or exploitation of clients within 24 hours of the allegation to DSS.

A Special Touch, Inc. shall prohibit any unauthorized restrictive interventions on all clients within the facility that does not adhere to the standards of this section.

A Special Touch, Inc. shall require that all personnel be trained in restrictive interventions techniques.

**PREVENTION OF PROBLEM**

A Special Touch, Inc. shall adhere to the requirements as written in the standards as stated in this attached section.

A Special Touch, Inc. shall ensure that all personnel are trained in the required restrictive intervention.

**MONITOR OF THE SITUATION**

A Special Touch, Inc. Executive Director and Qualified Professional shall conduct the monitoring.

**MONITORING TIME FRAME**

A Special Touch, Inc. timeframe is based on the reporting of required incidents and the certification of receiving restrictive intervention training.