STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AUBREY'S SAFE HAVEN	837 LYNHAVEN DRIVE GASTONIA, NC 28052

(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 A follow up survey was completed on 07/20/2023. 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 and 1 former client. The Surveyor was unable to determine if the previously cited deficiency (V114) was corrected during this survey due to insufficient time to review for compliance.	{V 000}		
{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	{V 109}		

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{V 109}	Continued From page 1 (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 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 records review and interviews, 1 of 1 Qualified Professional (QP) and 1 of 1 Associate Professional (AP) failed to demonstrate competency in the knowledge, skills, and abilities required by the population served. The findings are: Review on 06/30/2023 of Client #1's record revealed. -16-years-old. -Admitted 03/10/2023. -Diagnoses of Post Traumatic Stress Disorder (PTSD) and Major Depressive Disorder. -Comprehensive Clinical Assessment dated 03/07/2023 revealed: History of suicidal ideations. Review on 06/30/2023 of Client #2's record revealed:	{V 109}		

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{V 109}	Continued From page 2	{V 109}		

-11-years-old.
-Admitted 09/04/2022.
Diagnoses of Unspecified Bipolar and Related Disorder, Reactive Attachment Disorder, Oppositional Defiant Disorder, Child Neglect (confirmed), and PTSD.
-Psychology Evaluation dated 08/16/2022 revealed: History of behavioral and emotional issues, neglect, attachment issues, irritability, and minimal social and emotional responsiveness to others.

Review on 06/30/2023 of Client #3's record revealed:
-13-years-old.
-Admitted 02/25/2023.
-Diagnoses of Autism Spectrum Disorder, Conduct Disorder and Attention Deficit Hyperactivity Disorder.
-Psychology Evaluation dated 03/15/2021 and 03/31/2021 revealed: History of lying, theft, damaging property, harming animals, harming sibling, difficulties with black and white thinking, being uncomfortable with and confused by unpredictability, poor social understanding, and fixation on death.

Reviews on 06/30/2023 and 07/18/2023 of the AP's personnel record revealed:
-Hire date 03/27/2023.
-Job title AP.
-Job description undated and unsigned by the AP revealed: "Staff also monitor,
treat, and assess the emotional, psychiatric and behavioral needs of this special population, and assist with coordinating service needs for children or adolescents. Associate professional staff is responsible for the management of the
day-to-day operations of the facility; supervision of paraprofessional staff regarding responsibilities

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{V 109}	Continued From page 3 related to the implementation of each child or adolescent's treatment plan; and participation in treatment plan meetings. Staff is responsible for individualized supervision and structure of daily living for residents... Maintain accurate and timely documentation of need for services, services provided and service outcomes for all assigned clinical cases and services in accordance with North Carolina DD/MH/SAS standards..." Review on 07/18/2023 of the QP's personnel record revealed: -Hire date 01/25/2022. -Job title QP. -Job description undated and unsigned by the QP revealed: "... Staff also monitor, treat, and assess the emotional, psychiatric, and behavioral needs of this special population, and assist with coordinating service needs for children or adolescents. The Qualified Professional also will provide clinical supervision to all AP and direct staff of Aubrey's Safe Haven LLC (Licensee). Staff will participate in treatment planning meetings and are responsible for coordination of each child or adolescent's treatment plan... Maintain accurate and timely documentation of need for services, services provided and service outcomes for all assigned clinical cases and services in accordance with North Carolina DD/MH/SAS standards..." Interview on 07/20/2023 with the AP revealed: -Job title AP. -Employed since August 2022. -Was responsible for medications (MARs completion, physician orders, and medication refills for Clients #1, #2, and #3). -Did not ensure Clients #1, #2, and #3's medications were administered and documented as required.	{V 109}		

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{V 109}	Continued From page 4 Interview on 06/30/2023 with the QP revealed: -Job title QP. -Employed since 2021. -Did not ensure completion of treatment strategies for Client #3. -Was responsible for medications (MARs completion, physician orders, and medication refills for Clients #1, #2, and #3). -Did not ensure Clients #1, #2, and #3's medications were administered and documented as required. Interviews on 06/29/2023 and 06/30/2023 with the Executive Director/Licensee revealed: -AP was responsible for medications (MARs completion, physician orders, and medication refills). -Did not ensure the QP completed Client #3's treatment strategies. -Did not ensure the AP and QP administered and documented Clients #1, #2, and #3's medications as required. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	{V 109}		
{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:	{V 112}		

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{V 112}	Continued From page 5 (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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement treatment strategies to address the needs of the clients affecting 1 of 3 audited Clients (#3). The findings are: Review on 06/30/2023 of Client #3's record revealed: -13-years-old. -Admitted 02/25/2023. -Diagnosed with Autism Spectrum Disorder, Conduct Disorder and Attention Deficit Hyperactivity Disorder. -Psychology Evaluation dated 03/15/2021 and 03/31/2021 revealed: "[Client #3] displays	{V 112}		

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{V 112}	Continued From page 6 significant difficulties with defiance and aggression. [Client #3]'s Guardian provided a written symptom journal spanning 1.5 years documenting the behavioral symptoms that [Client #3] has displayed. In the journal, repeated incidences of outright lying, theft, damaging property, harming animals (hurting family pets on purpose, destroying birds' eggs, attempting to kill a lizard, and harming her little brother were reported... Difficulties with black and white thinking, being uncomfortable with and confused by unpredictability, poor social understanding, and a fixation on death were also reported." -No treatment plan and/or treatment strategies to address Client #3's difficulties with defiance, aggression, lying, theft, property destruction, harm of animals and others, difficulty with thinking, confusion with unpredictability, poor social understanding, or fixation on death since facility admission. -Treatment plan signature page dated 06/29/2023 and signed by the Therapist and Client #3's Guardian. Interview on 06/30/2023 with Client #3 revealed: -"I have been here for 5 months." -Did not know if she participated in a treatment team meeting. Interview on 07/20/2023 with the Associate Professional (AP) revealed: -"[Executive Director (ED)/Licensee (L)] and Qualified Professional (QP) were responsible for treatment plans." Interview on 06/30/2023 with the QP revealed: -"I do CFT (Child and Family Team) meetings." -Was responsible for developing treatment strategies for Client #3. -Did not complete treatment strategies for Client	{V 112}		

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{V 112}	Continued From page 7 #3. Interview on 06/30/2023 with the ED/L revealed: -"We had her (Client #3) treatment team meeting yesterday (06/29/2023). We have 24 hours for the QP to complete the treatment plan." -Did not ensure completion of treatment strategies for Client #3. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	{V 112}		
{V 118}	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the	{V 118}		

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{V 118}	Continued From page 8 drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered on the written order of a physician and the MAR kept current affecting 3 of 3 Clients (#1, #2, and #3). The findings are: Finding #1: Review on 06/30/2023 of Client #1's record revealed. -16-years-old. -Admitted 03/10/2023. -Diagnosed with Posttraumatic Stress Disorder (PTSD) and Major Depressive Disorder. -Medication orders dated 03/22/2023 revealed: "Cetirizine (Allergies) 10 milligram (mg)- Take 1 tablet (tab) every morning, Montelukast (Asthma) 10 mg- Take 1 tab every morning, Fluticasone (Asthma)- 2 Puffs daily every morning, and Topiramate (Mood Stabilizer) 25 mg- Take 1 tab at bedtime and Trazodone (Sleep Aid) 50 mg- Take 1 and ½ tabs at bedtime." -No medication order for Aripiprazole (Mood Stabilizer) 5 mg- Take 1 tab by mouth at bedtime. Review on 06/29/2023 of Client #1's MARs from	{V 118}		

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{V 118}	Continued From page 9 05/19/2023 - 06/29/2023 revealed: -MAR dated May 2023 was missing transcription for: the quantity of the medication, date, or time the medication was to be administered for all medications listed above for Client #1. -No June 2023 MAR. Review on 06/29/2023 of Client #1's untitled daily medication signature logs for the "AM" and "PM" from 05/19/2023 - 06/29/2023 revealed: -Multiple dates with staff signatures, but no transcription for the name, strength, and quantity of the medication; instructions for administering the medication; and/or time the medication was to be administered. -No "AM" staff signatures for 06/06/2023, 06/07/2023, 06/20/2023, 06/23/2023, 06/25/2023, and 06/27/2023. -No "PM" staff signatures for 06/02/2023, 06/12/2023, 06/13/2023, 06/14/2023, 06/20/2023, 06/22/2023, 06/23/2023, 06/27/2023, and 06/28/2023. -15 doses of medications missing staff signatures. Observation on 06/29/2023 at approximately 1:25 pm of Client #1's medication container revealed: Missing the following medications: -Cetirizine 10 mg tab-Take 1 tab by mouth every morning. -Montelukast 10 mg tab-Take 1 tab by mouth every morning. -Topiramate 25 mg tab- Take 1 tab by mouth at bedtime. -Fluticasone Inhaler-2 Puffs daily every morning. Observation on 07/18/2023 at approximately 11:14 am of Client #1's medication container revealed: -Cetirizine 10 mg tab-Take 1 tab by mouth every	{V 118}		

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{V 118}	Continued From page 10	{V 118}		

morning dispensed 07/05/2023.
-Montelukast 10 mg tab-Take 1 tab by mouth every morning dispensed 07/05/2023.
-Topiramate 25 mg tab- Take 1 tab by mouth at bedtime dispensed 07/05/2023.
-Fluticasone Inhaler-2 Puffs daily with no dispense date.

Finding #2:

Review on 06/30/2023 of Client #2's record revealed:
-11-years-old.
-Admitted 09/04/2022.
-Diagnosed with Unspecified Bipolar and Related Disorder, Reactive Attachment Disorder, Oppositional Defiant Disorder, Child Neglect (confirmed), and PTSD.
-Medication orders dated 02/21/2023 revealed: "Guanfacine (Mood Stabilizer) 1 mg- Take 1 and ½ tab by mouth at bedtime, Vistaril (Anxiety) 25 mg- Take 1 capsule by mouth every night, and Aripiprazole (Mood Stabilizer) 5 mg- Take ½ tab every morning and ½ tab every night."
-No medication order for Montelukast (Asthma) 10 mg- Take 1 tab every evening.

Review on 06/29/2023 of Client #2's MARs from 05/19/2023 - 06/29/2023 revealed:
-MAR dated May 2023 was missing transcription for: the quantity of the medication, date, or time the medication was to be administered for all medications listed above for Client #2.
-No June 2023 MAR.

Review on 06/29/2023 of Client #2's untitled daily medication signature logs for the "AM" and "PM" from 05/19/2023 - 06/29/2023 revealed:
-Multiple dates with staff signatures, but no transcription for the name, strength, and quantity

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{V 118}	Continued From page 11 of the medication; instructions for administering the medication; and/or time the medication was to be administered. . -No "AM" staff signatures for 06/03/2023, 06/04/2023, 06/06/2023, 06/07/2023, 06/12/2023, and 06/13/2023. -"No medications (med) or out of meds" written on "AM" signature log for 06/16/2023, 06/17/2023, 06/18/2023, 06/19/2023. -No "PM" staff signatures for 06/02/2023, 06/04/2023, 06/07/2023, 06/12/2023, 06/13/2023, 06/14/2023, 06/20/2023, 06/22/2023, 06/23/2023, 06/27/2023, and 06/28/2023. -21 doses of medications missing staff signatures. Finding #3: Review on 06/30/2023 of Client #3's record revealed: -13-years-old. -Admitted 02/25/2023. -Diagnosed with Autism Spectrum Disorder, Conduct Disorder and Attention Deficit Hyperactivity Disorder (ADHD). -Medication orders dated 04/21/2023 and 05/22/2023 revealed: "Guanfacine (ADHD) ER (Extended Release) 3 mg-Take 1 tab every evening, D-Amphetamine Salt Combo (ADHD) 15 mg- Take 1 tab by mouth every morning, Aripiprazole (Mood Stabilizer) 15 mg- Take 1 tab by mouth daily, and Clonidine (Mood Stabilizer) 0.2 mg- Take 1 tab by mouth every evening. Review on 06/29/2023 of Client #3's MARs from 05/19/2023 - 06/29/2023 revealed: -MAR dated May 2023 was missing transcription for: the quantity of the medication, date, or time the medication was to be administered for all medications listed above for Client #3.	{V 118}		

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{V 118}	Continued From page 12 -No June 2023 MAR. Review on 06/29/2023 of Client #3's untitled daily medication signature logs for the "AM" and "PM" from 05/19/2023 - 06/29/2023 revealed: -Multiple dates with staff signatures, but no transcription for the name, strength, and quantity of the medication; instructions for administering the medication; and/or time the medication was to be administered. -No "AM" staff signatures for 06/04/2023, 06/05/2023, and 06/20/2023. -No "PM" staff signatures for 06/02/2023, 06/03/2023, 06/07/2023, 06/08/2023, 06/12/2023, 06/13/2023, 06/22/2023, and 06/23/2023. -11 doses of medications missing staff signatures. Interview on 06/30/2023 with Client #1 revealed: -"I have been out of meds for 2 weeks. I am out of my allergy and night meds." Interview on 07/18/2023 with Client #1 revealed: -"I have been getting my medications since the 5th (July 2023)." Interview on 06/30/2023 with Client #2 revealed: -Received medications as prescribed. Interview on 06/30/2023 with Client #3 revealed: -Received medications as prescribed. Interview on 06/29/2023 with Staff #2 revealed: -"We were just about to go to the pharmacy. One of the clients (Client #1) ran out of her AM meds." -"No, she (Client #1) ran out of it (medication) today." Interview on 07/20/2023 with the Associate Professional (AP) revealed:	{V 118}		

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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 118}	Continued From page 13 -Was responsible for medications (MARs completion, physician orders, and medication refills for Clients #1, #2, and #3). -"That (MARs missing required components) was my fault." -"When I printed them (MARs) out the time was missing." -"I was not aware that she (Client #1) was out of meds." -"I try to fill their (Clients #1, #2, and #3) meds after their medication management appointment." Interview on 06/30/2023 with the Qualified Professional (QP) revealed: -"I oversee all the medications." -"I make sure medications are administered right." -"I thought it (MARs) was corrected. We had a meeting about the MARS to make sure everybody (facility staff) was on the same page." -"She (Client #1) should not have been without medications. I tried to get the girls set up on auto-refill, but they (pharmacy) would not do it. Maybe because of the medications they take." -"I am going to take care of all of this (medication administration issues), this weekend. I am going to redo the MARs and I will make sure everything is filled correctly." Interviews on 06/29/2023 and 06/30/2023 with the Executive Director (ED)/Licensee (L) revealed: -"When I got cited, I reached out to [nurse practitioner] and asked her what MAR I needed ... I sent it to [AP] to put their (Clients #1, #2, and #3) medications in and I got this MAR (incorrect)." -"[AP] changed it (the MAR format)." -"She (Client #1) had meds available at the pharmacy. I told the staff to get the meds. I will contact her doctor and ensure I get on the books every 20 -25 days to ensure we do not run out of	{V 118}		

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{V 118}	Continued From page 14	{V 118}		

meds. I will also see if we can sign her up for auto fill at the pharmacy."
-"[Client #3]'s MAR should have been updated to show that she had a change to her meds."
-"We get an emergency supply (of medications) to make sure the girls don't run out of meds."

Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician.

Review on 07/19/2023 of the Plan of Protection (POP) dated 07/19/2023 written by the ED/L revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care?
-Aubrey's Safe Haven (Licensee) QP and AP will make sure that the MARS and the physician order match. While the ED (ED/L) make sure there is no missing medication. The QP will go behind the ED to make sure that all the clients are receiving their medication at a timely matter and there is no missing medication.
Describe your plans to make sure the above happens.
-The plan for the AP and QP to go through every clients medication container and make sure their medication on both the MARS and the physician orders matches and up to date. The ED will schedule all doctor appointments for every client within 20-25 days so the medication will not run out and to contact the pharmacy to see if there a way to enroll into auto fill for the prescription. The QP will work hand and hand with the ED to make sure that all client are receiving morning and nights and there are no missing medication."

Review on 07/19/2023 POP Addendum #2 dated 07/19/2023 written by the ED/L revealed the

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{V 118}	Continued From page 15 following updated information: "What immediate action will the facility take to ensure the safety of the consumers in your care? -Aubrey's Safe Haven [Nurse Practitioner] will make sure that the MARS and the physician order match. While the ED make sure there is no missing medication. The [Nurse Practitioner] will go behind the ED to make sure that all the clients are receiving their medication at a timely matter and there is no missing medication. Describe your plans to make sure the above happens. -The plan for the AP and QP to go through another training with [Nurse Practitioner] on Tuesday July 25th, 2023. -[Nurse Practitioner] also will make sure The ED will schedule all doctor appointments for every client within 20-25 days so the medication will not run out and to contact the pharmacy to see if there a way to enroll into auto fill for the prescription. -[Nurse Practitioner] will work hand and hand with the ED and QP to make sure that all clients are receiving morning and nights and there is no missing medication by scheduling the clients appointments will be within those 20-25 day effective July 25th 2023. ." Review on 07/19/2023 POP Addendum #3 dated 07/19/2023 written by the ED/L revealed the following updated information: "What immediate action will the facility take to ensure the safety of the consumers in your care? - On July 25th, 2023, [Nurse Practitioner] who is a nurse practitioner will start overseeing everything. Describe your plans to make sure the above happens. -To go over every client's medication container and make sure their medication on both the MARS and the physician orders matches and up	{V 118}		

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{V 118}	Continued From page 16 to date. -[Nurse Practitioner] is a nurse practitioner who does the medication management for our clients in the home. Also, she conducts all the med administration training for Aubrey's Safe Haven. Effective July 25th, 2023 [Nurse Practitioner] will oversee MARS, physician order and making sure that all medication is available at all times." Clients #1, #2, and #3 were between 11-16 years old. Their diagnoses included but were not limited to PTSD, ADHD, DMDD, Autism Spectrum Disorder, Conduct Disorder, and Major Depressive Disorder. Staff administered medications to Clients #1 and #2 without physician orders. MARs for Clients #1, #2, and #3 did not have the quantity of the medication, date, and time the medication was to be administered as required. In addition, Clients #1, #2, and #3 were missing entries and/or staff signatures on the daily medication staff signature log used by the facility. Client #1 had 15 doses of undocumented medication administration entries. In addition, four medications were observed missing from her medication bin on 06/29/2023 and were not filled by the pharmacy until 07/05/2023. Client #2 had 21 doses of undocumented medication administration entries. Client #3 had 11 doses of undocumented medication administration entries. This deficiency constitutes a Failure to Correct the 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 118}		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing	V 296		

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V 296	Continued From page 17 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the	V 296		

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V 296	Continued From page 18 child or adolescent's individual strengths and needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure minimum staffing requirements of two staff for up to four adolescents. The findings are: Observation upon arrival to the facility on 06/29/2023 at 1:10 pm revealed: -Staff #2 alone with Clients #1, #2, and #3. Observation upon arrival to the facility on 06/30/2023 at 10:10 am revealed: -Staff #1 alone with Clients #1, #2, and #3. Observation upon arrival to the facility on 07/18/2023 at 10:30 am revealed: -Staff #3 alone with Clients #1, #2, and #3. Review on 06/30/2023 of Client #1's record revealed. -16-years-old. -Admitted 03/10/2023. -Diagnoses of Post Traumatic Stress Disorder (PTSD) and Major Depressive Disorder. -Comprehensive Clinical Assessment dated 03/07/2023 revealed: History of suicidal ideations. Review on 06/30/2023 of Client #2's record revealed:	V 296		

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V 296	Continued From page 19	V 296		

-11-years-old.
-Admitted 09/04/2022.
Diagnoses of Unspecified Bipolar and Related Disorder, Reactive Attachment Disorder, Oppositional Defiant Disorder, Child Neglect (confirmed), and PTSD.
-Psychology Evaluation dated 08/16/2022 revealed: History of behavioral and emotional issues, neglect, attachment issues, irritability, and minimal social and emotional responsiveness to others.

Review on 06/30/2023 of Client #3's record revealed:
-13-years-old.
-Admitted 02/25/2023.
-Diagnoses of Autism Spectrum Disorder, Conduct Disorder and Attention Deficit Hyperactivity Disorder.
-Psychology Evaluation dated 03/15/2021 and 03/31/2021 revealed: History of lying, theft, damaging property, harming animals, harming sibling, difficulties with black and white thinking, being uncomfortable with and confused by unpredictability, poor social understanding, and fixation on death.

Interview on 06/30/2023 with Client #1 revealed:
-Was admitted March 10th (2023).
-"It is rare for two staff to be here. Typically, 5 out of 7 days a week there is only one staff."

Interview on 06/30/2023 with Client #2 revealed:
-"I have been here 9 to 10 months."
-"It used to be two staff when it was four of us (clients). Most of the time, we are here with only one staff."

Interview on 06/30/2023 with Client #3 revealed:
-"I have been here for 5 months."

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V 296	Continued From page 20 -"It (only one staff on duty) happens a lot. Mostly every day we have one staff." Interview on 06/30/2023 with Staff #1 revealed: -"Since May 30th there has been only one staff with the girls during the day and in the evening more staff come." Interview on 07/18/2023 with Staff #2 revealed: -"The other staff is on her way." -Usually worked with another staff. -"Staff will ask if they can leave to go to the store to get chips or something and don't tell them they cannot go." Interview on 06/30/2023 with the Qualified Professional revealed: -"We (facility) usually have two staff there. It was two staff and then one young lady quit." Interview on 07/18/2023 with the Executive Director/Licensee revealed: -" I was told by someone from the State that one staff can go and run errands and the other staff could stay with the clients." -"I used to have 2 staff, but since we have 3 girls that are good. I was told by CPS (Child Protective Services) that it could be 1 staff." -"It has not been long (out of staff and client ratio)."	V 296		
{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	{V 366}		

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{V 366}	Continued From page 21 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 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;	{V 366}		

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{V 366}	Continued From page 22 (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The 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	{V 366}		

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{V 366}	Continued From page 23 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 governing their response to level II and III incidents. The findings are: Reviews on 06/29/2023 and 07/18/2023 of the facility records revealed: -No Risk/Cause/Analysis for level II incidents dated 01/05/2023, 01/09/2023, 03/24/2023, and 03/25/2023. -No Risk/Cause/Analysis or submission of the written preliminary findings of fact to the Local Management Entity/Managed Care Organization (LME/MCO) within five working days for level III alleged abuse incident against Staff #1 for popping FC #4 in the mouth with an open fist. Interview on 06/30/2023 with the Qualified Professional revealed: -"I thought that (Risk/Cause/Analysis) was done. I will get the information." -Did not complete the Risk/Cause/Analysis for incidents dated 01/05/2023, 01/09/2023,	{V 366}		

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{V 366}	Continued From page 24 03/24/2023, and 03/25/2023. -Did not complete the Risk/Cause/Analysis or submit the written preliminary findings of fact to the LME/MCO within five working days for the alleged abuse incident against Staff #1 for popping FC #4 in the mouth with an open fist. Interviews on 07/18/2023 and 07/20/2023 with the Executive Director/Licensee revealed: -"I did the risk management." -Did not complete the Risk/Cause/Analysis for incidents dated 01/05/2023, 01/09/2023, 03/24/2023, and 03/25/2023. -Did not complete the Risk/Cause/Analysis or submit the written preliminary findings of fact to the LME/MCO within five working days for alleged abuse incident against Staff #1 for popping FC #4 in the mouth with an open fist. -Would complete the Risk/Cause/Analysis and submit the written preliminary findings of fact to the LME/MCO within five working days for alleged abuse incident for FC #4. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	{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	{V 367}		

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{V 367}	Continued From page 25	{V 367}		

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 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

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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 367}	Continued From page 26 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; (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 III incidents in the	{V 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-371	A. BUILDING: _____ B. WING _____	R 07/20/2023

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{V 367}	Continued From page 27 Incident Response Improvement System (IRIS) and notify the Local Management Entity (LME)/Managed Care Organization (MCO) responsible for the catchment area where services were provided within 24 hours of becoming aware of the incident. The findings are: Reviews on 06/29/2023 and 07/18/2023 of the facility records revealed: -No IRIS report or LME/MCO notification for Staff #1 popping FC #4 in the mouth with an open fist. Reviews on 06/29/2023 and 07/18/2023 of IRIS revealed: -No IRIS report submitted for the incident identified above. Interview on 06/30/2023 with the Qualified Professional revealed: -"I thought that (IRIS reports) was done. I will get the information." -Did not complete an IRIS report or notify the LME/MCO within 24 hours of becoming aware of the incident involving Staff #1 popping FC #4 in the mouth with an open fist. Interviews on 07/18/2023 and 07/20/2023 with the Executive Director/Licensee revealed: -"I completed the IRIS reports back in May (2023)." -Did not complete an IRIS report or notify the LME/MCO within 24 hours of becoming aware of the incident involving Staff #1 popping FC #4 in the mouth with an open fist. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	{V 367}		

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{V 500}	Continued From page 28	{V 500}		
{V 500}	27D .0101(a-e) Client Rights - Policy on Rights 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 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. (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: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (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: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an	{V 500}		

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{V 500}	Continued From page 29 involuntary client who refuses the use of restrictive interventions. (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: (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); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure all incidents of alleged abuse are reported to the County Department of Social Services (DSS). The findings are: Reviews on 06/29/2023 and 07/18/2023 of the facility records revealed: -No notification to the County DSS for the allegation of Staff #1 popping Former Client (FC) #4 in the mouth with an open fist incident. Reviews on 06/29/2023 and 07/18/2023 of North Carolina Incident Response Improvement System revealed:	{V 500}		

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{V 500}	Continued From page 30 -No notification to the County DSS for the allegation of Staff #1 popping FC #4 in the mouth with an open fist incident. Review on 07/18/2023 of a document titled "Gaston County Department of Health and Human Services" revealed: -No DSS report for Staff #1. Interview on 06/30/2023 with the Qualified Professional revealed: -"I thought we did that (DSS notification)." -Did not notify the County DSS of the allegation of Staff #1 popping FC #4 in the mouth with an open fist incident. Interview on 07/18/2023 the Executive Director/Licensee revealed: -Notified DSS of the allegation of Staff #1 popping FC #4 in the mouth with an open fist incident. -"I don't know why the letter says "family" and not [Staff #1]'s name. I will reach back out [DSS Representative] and have her to redo the letter." This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	{V 500}		