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	MHL0601347	A. BUILDING: _____ B. WING _____	10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW FOUNDATION	5419 TWIN LANE CHARLOTTE, NC 28269

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 10/06/23. The complaints were substantiated (Intake #NC00205817, #NC00206473). 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 3 and currently has a census of 2. The survey sample consisted of audits of 2 current clients and 1 former client.	V 000		
V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments.	V 120		

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This Rule is not met as evidenced by:
Based on record review, observations and interviews, the facility failed to ensure 1 of 3 clients (client #2) medication was stored in a securely locked cabinet. The findings are:

Review on 8/18/23 of client #2's record revealed:
- Admitted 2/27/18;
- Age 17;
- Diagnoses- Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Post Traumatic Stress Disorder;
- Physician orders dated 5/24/23: Quetiapine Fumarate Seroquel 50 milligrams (mg), Take one tablet by mouth at bedtime for sleep; Bupropion HCL XL Wellbutrin(Antidepressant) 150 mg tablet, Take one tablet by mouth every morning.

Review on 8/18/23 of Former Client (FC) #3's record revealed:
- Admitted date 7/17/23;
- Age 17;
- Diagnoses-Disruptive Mood Dysregulation Disorder, Post Traumatic Stress Disorder , Alcohol Use Disorder, In a Controlled Environment, Nicotine Use Disorder, In a Controlled Environment, Cannabis Use Disorder, In a Controlled Environment, Borderline Intellectual Functioning, history of Suicidal Behavior, History of Non-suicidal Self Injury, Upbringing Away From Parents;
- Discharge date 8/8/23.

Review on 9/15/23 of FC 3's medical records from local hospital revealed:
- Admitted on 8/8/23 at 10:37pm;
- Chief Complaint "17-year-old presents EMS

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from Group Home for intentional overdose. Unsure exact time that is happened, patient reported "a few hours ago" when EMS arrived (unsure when that time was) - will use arrival time as her ingestion time. Unclear exactly how much medicine patient ingested but at the very least would have been 12 tablets of the 150 mg Wellbutrin and 4 tablets of the 50 mg Seroquel. Patient had reported that she took more than that and attempt to harm herself. She does not give me(physician) any additional information when I evaluate her."
- At 12:15am on 8/9/23 FC #3 started having seizures throughout the night lasting 10-15 seconds;
- FC #3 was assigned to PICU (Pediatric Intensive Care Unit);
- FC #3 was intubated (insert of tube in trachea for ventilation) from 8/9/23-8/11/23;
- Transferred to Pediatric floor after extubation (removal of tube used to assist with ventilation) on 8/11/23.
- Initially had some short term memory deficits, but these resolved within 24 hours.
- Medically cleared on 8/12/23;
- Remained in local hospital until placement is found.

Review on 8/18/23 of the Incident Response Improvement System (IRIS) revealed:
- On 7/21/23, "the consumer [FC #3] had talked to staff and told staff she was upset. After talking to the staff the consumer (FC #3) went into the bathroom. After about 5 minutes of being in the bathroom the staff accessed the bathroom and saw the consumer with blood on her arm and shirt. While talking with the staff the consumer made the statement that she wanted to kill herself. Staff contacted the Executive Director and notified him of the situation and after the

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consumer continued to make self-harm statements and the Executive Director decided to call the paramedics for a fair assessment of the consumers self-harm behaviors. The consumer was transported to the local hospital. She was kept overnight for an assessment and was released on the following day without further incident."

- On 7/28/23, FC #3 expressed that she was having anxiety. Later she went into the bathroom and locked the door. As staff prompted her to come out, she expressed her self-harm feeling. Staff called 911 for assistance. Once the local police and paramedics arrived the consumer surfaced from the bathroom with superficial scratches on her left forearm. She was transported to the local hospital where she was assessed and released back to the facility.
- On 8/1/23, FC #3 was "upset because she could not get in contact with a support staff from a previous placement. One of her peers coerced her into self-harm by saying "just do it" after the consumer made self harm statement. The consumer then proceeded to breaking a glass jar of sugar to use the glass to cut herself several times superficially on her arm. The paramedics were called and transported her to local hospital where she was treated overnight and released on 08/02/2023."
- On 8/3/23, FC #3, pushed staff #1 while being administered ibuprofen and took the pill bottle into the bathroom. FS #3 was able to get the ibuprofen back from FC #3 From the bottle count it seemed that she could have taken up to 10 Ibuprofen.
- On 8/8/23, FC #3, gained access to the medication closet and obtained 4 bubble packs of medications (Bupropion HCL XL 150 milligrams (mg), quantity 90; Quetiapine Fumarate 50mg, quantity 30). FC #3 was taken to the hospital for

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V 120	Continued From page 4 overdose. Review on 8/22/23 of the Facility's Investigation Summary dated 8/12/23 revealed: -"Incident: On 08/08/23 Executive Director received a call from Residential Counselor [FS #3] stating that [FC #3] had her stated that she was not feeling well. And that she had possibly overdosed on medications as she presented several empty bubble packs of medication consisting of Quetiapine Fumarate and Bupropion HCL XL. [Executive Director] asked [FS #3] to attend to the consumers medical need and that EMS (Emergency Medical Services) should be called to assist. [Executive Director] spoke with the consumer at the date and time and inquired of the consumer of the possible overdose. When asked where and how she got the medications she stated that she had obtained them medication on "first shift" and that she wanted to die ....[FS #3] statement at this time was the consumer informed her prior to going to the hospital that she had gained access to medications earlier in the day because [House Manager/QP] had left the medication closet unlocked. Around 1am on 8/9/23 ER staff informed [Executive Director] that they were treating the consumer with charcoal as she had actually taken the medication in an attempt to overdose." -Interviews: - "On the morning of 08/09/23 [Executive Director] conducted an interview with client #1. When asked if she had acknowledge of the events on 08/08/23 which led to her peer consumer [FC #3] being transported to the hospital she stated that she had received the house keys from [FS #3] to retrieve an item form (from) from the closet and she was not sure if she had locked the closet back. She stated that she	V 120		

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did not see the consumer go into the closet at anytime nor did she see the consumer with any medications or medication bubble packs and only had knowledge of the incident as she observed the EMS transporting the consumer from the facility."

- "On the morning of 08/09/23 [Executive Director] conducted an interview with consumer [Client #2]. When asked if she had any knowledge of the incident involving her peer [FC #3] she stated that she witnessed [FS #3] give consumer [Client #1] the house keys to get something out of the closet for [FS #3] but do not know what it was that [Client #1] retrieved. [Client #2] stated that she never saw the consumer [FC #3] with any medications or any medication bubble packs and was not sure if [Client #1] had locked the medication back or not. She also stated that she did not know of the consumer [FC #3] overdosing until the EMS arrived."

- "On the morning of 08/09/23 a formal interview was conducted by [Executive Director] with [FS #3] revealing she had no idea of how the consumer [FC #3] obtained the medication and she did not know how she obtained the medication or when she took them. When questioned about giving the medication closet keys to [Client #1], she admitted that she did so in lapse of judgement without thinking that it could affect [FC #3]. She also stated that she did not check the medication closet after consumer {client #1} had access to it to assure it was locked. At that point [FS #3] was immediately removed from the work schedule and terminated on 8/11/23 for failure to follow program policy."

- "On 08/09/23 an interview with the [House Manager/Qualified Professional] was conducted by [Executive Director]. When questioned about the consumer [FC #3] and her interactions during first shift on 08/08/23. [House Manager/QP]

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V 120	Continued From page 6 stated that the consumer had been with her 90% of the time on the date of the incident and would not have had the time or opportunity to get into the medication closet. When asked if she retained possession of the medication closet keys on 08/08/23 she stated they never left her possession." - "Conclusion: From observation of physically checking the medication closet and locked medication boxes on 08/09/23 it has been determined that all consumers' medication boxes were locked with a padlock however the overflow (refill) medication box was not locked as it did not have a lock on it. Once each medication box was checked each consumer had all prescribed medications which matched the current medication count log. It is perceived that [FS #3] allowed a consumer [Client #1] to go into the medication closet which is against agency policy and did not supervise the consumer [FC #3] while allowing her to access the medication closet and she did not check to verify the closet being locked. This allowed the consumer to access the medication closet and remove medication from the overflow (refill) medication box. An ongoing investigation is ongoing to determine the number of pills the consumer was able to take during the suicide attempt and at what time she secured the medications, and how she was able to take the number of pills she did without staff noticing." Interview on 8/18/23 and 8/24/23 with Client #1 revealed: - Didn't know how FC #3 obtained access to the medication; - [FS #3] unlocked the door and I got the [cleaning agent] out because I was cleaning up my room. i closed the door back and locked it."; - Never told anyone that I had the keys to the cleaning closet.";	V 120		

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V 120	Continued From page 7 - Denied staff gave clients their keys. Interview on 8/15/23 with FC #3 at local hospital revealed: - Was unable to remember taking medications (Bupropion HCL XL 150 milligrams (mg); Quetiapine Fumarate 50mg) that led to overdose hospitalization on 8/8/23; - Unable to remember how she obtained access to the medications taken when she overdosed on 8/8/23; - Staff kept the keys for the medication and cleaning supplies closet in an unlocked desk drawer in staff's office; - Staff office was always unlocked. Interview on 8/23/23 with Former Staff #3 revealed: - Was terminated due to FC #3 gaining access to medications and overdosed on 8/8/23; - On 8/8/23, completed a walkthrough of the home at the start of shift and didn't see "anything out of the ordinary." - I did an "eye check", the medication closet was "closed and locked"; - The keys to the closet were sitting on the desk in the staff office with the House Manager/QP; - Asked about cleaning supplies while prepping dinner; - Client #1 went to the medication closet and stated the door was open; - "[House manager/QP] stated 'I know it's not because I locked it'"; - Made sure the medication door was now locked and gained possession of the medication/ cleaning supply closet keys; - FC #3 came to the kitchen to speak with FS #3 but was ask to give a few minutes due to FS #3 preparing dinner; - FS #3 noticed FC #3 had slurred speech when	V 120		

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V 120	Continued From page 8 she returned to the kitchen to speak with her; - FS #3 questioned FC #3 about what she had done; - FC #3 asked FS #3 to come walk down the hallway with her, to her bedroom; - FC #3 gave FS #3 four packs of client #2's bubble packs of medication; - Emergency Medical Services (EMS) transported FC #3 to the local hospital. Interview on 8/24/23 with the House Manager/QP revealed: - Duties were to check the Medication Administration Records (MAR) every morning, make sure medications were in the facility at all times, administer medications when staff were busy, make sure client appointments are made and kept; - Staff were written up and a picture was taken of keys if they were laying around and not in staff's possession; - At the start of each shift "I make sure the door (medication/cleaning supply) is locked, before I receive the keys from staff." - There were two sets of keys used to obtain access to the medications in the closet; - Overflow medications were kept in a box inside of the medication closet; - "I can't remember if the box had a lock on it."; - "[Client #1] never made reference to the closet (medication/cleaning supply) door being opened."; - Administered medications to FC #3 before leaving for the evening on 8/8/23; - On 8/8/23, "I don't know how [FC #3] was able to get into the closet, I had my keys on me at all times. When I got ready to go, I laid the keys and the remote on the desk and called for [FS #3], to let her know the keys and remote were on the desk.";	V 120		

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V 120	Continued From page 9 - FS #3 was alone at the home with the three clients for about an hour on 8/8/23; - "There is no time that the key will be given to a client for them to open the closet or to retrieve any items."; - "We no longer keep the overflow medications here." Interview on 8/22/23 with the Executive Director revealed: - Received a call on 8/8/23 from FS #3, FC #3 had obtained access to the medication closet and taken client #2's medication that was in the overflow box; - Client #1 stated she received the keys to the medication closet from FS #3 on 8/8/23; - Client #1 was not sure if she locked the closet back; - FC #3 reported she obtained the medications during 1st shift; - "Those medications were not locked up."; - Started an internal investigation on 8/9/23; - Investigation was still ongoing. Review on 9/18/23 of the Plan of Protection signed by Executive Director dated 9/18/23 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? There will be an immediate training to be held with the Qualified Professional (House Manager/QP) and Paraprofessionals (Residential Counselor and House Managers) to review scope to include specific population training. This will be done no later than 09/20/23. The Clinical Director will review all supervision plans and update them as needed to address paraprofessional competencies and identify areas of need. The medication closet keys have been placed on a separate key chain to separate the medication	V 120		

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closet keys from the medication box lock keys. Any and all staff are to assure that the keys are kept on the staff person at all times and handed directly to staff relieving them. There will no longer be a medication refill (overflow) box located at the home to store excess/refill medication.
Describe your plans to make sure the above happens.
As of 09/18/23 the Executive Director will conduct weekly checks of the facility to assure that the medication closet is locked and that the lock is working properly, check individual medication boxes to assure they have a padlock on them and that the lock is secured, conduct a medication count according to prescribed medication date and number of pills in the bubble pack while cross referencing the medication count with the Medication Administration Records (MAR). Upon arrival at the facility the Executive Director will verify that the staff on duty have possession of all keys on their body. If any of these aforementioned procedures are not being followed the Executive Director will issue a coaching to include being taken off of the schedule for a minimum of 3 days not to exceed 5 days. If there are repeated violations of the aforementioned by the same employees, they can face suspension up to termination."

The facility served 2 clients, 1 former client who ranged in ages from 12-17 years old with diagnoses Disruptive Mood Dysregulation Disorder , Post Traumatic Stress Disorder, Borderline Intellectual Functioning, history of Suicidal Behavior, History of Non-suicidal Self Injury, Attention Deficit Hyperactivity Disorder and Oppositional Defiant Disorder. FC #3 had a history of suicidal ideation. The House Manager/QP and FS #3 failed to ensure the

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V 120	Continued From page 11 medications were secure. FC ## was able to obtain and overdose on two psychiatric mediations belonging to client #2. This resulted in FC #3 emergency hospital admission and placement on a ventilator for two days. The legal guardian was not notified until the next day. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 120		
V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to a	V 293		

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V 293	Continued From page 12 community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to provide the necessary level of supervision and structure of daily living to minimize the occurrence of behaviors related to functional deficits and failed to coordinate with other individuals and agencies within the child and adolescent's system of care affecting 1 of 3	V 293		

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V 293	Continued From page 13 clients (Former Client (FC) #3). The findings are: Review on 8/18/23 of Former Client #3's record revealed: - Admitted date 7/17/23; - Age 17; - Diagnoses-Disruptive Mood Dysregulation Disorder, Post Traumatic Stress Disorder , Alcohol Use Disorder, In a Controlled Environment, Nicotine Use Disorder, In a Controlled Environment, Cannabis Use Disorder, In a Controlled Environment, Borderline Intellectual Functioning, history of Suicidal Behavior, History of Non-suicidal Self Injury, Upbringing Away From Parents; - Discharge date 8/8/23. Interview on 8/15/23 with Former Client #3 revealed: - Was unable to remember taking medications(Bupropion HCL XL 150 milligrams (mg), quantity 90; Quetiapine Fumarate 50mg, quantity 30) that lead to overdose hospitalization on 8/8/23; - Unable to remember how she gained access to the medications taken when she overdosed on 8/8/23; - Did not remember pushing staff #2 to gain access of a bottle of Ibuprofen on 8/3/23; - Staff kept the keys for the medication and cleaning supplies closet in the desk drawer unlocked in the staff's office; - Staff office was always unlocked. Interview on 8/15/23 with the Permanency Planning Social Worker with the local Department of Social Services revealed: - FC #3 was at the local hospital up and alert; - FC #3 was "experiencing short term memory loss, she not remembering the last 4-6 weeks."	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601347	A. BUILDING: _____ B. WING _____	10/06/2023

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V 293	Continued From page 14 - The On Call Social Worker for the local Department of Social Services was not contacted about the incident on 8/8/23; - Received a voicemail on 8/9/23 from the Executive Director stating "call me when you get a chance, I need to let you know [FC #3] overdosed last night. She is in a coma." - "There was no urgency in his voice when he called"; - Executive Director stated "a staff member gave keys to another client, and the client left door opened or gave the keys to [FC #3]"; - FC #3 was ready for medical discharge from the local hospital; - Was unable to find placement for FC #3. Interview on 8/22/23 with the Executive Director revealed: - Received a call on 8/8/23, FC #3 had gained access to the medication closet and taken client #2's medication that was in the refill box; - Contacted the legal guardian of FC #3 on the morning of 8/9/23, due to phone dying while at hospital and forgot to call upon returning home at 1:30am;	V 293		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective	V 366		

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V 366	Continued From page 15	V 366		

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;
(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

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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 different;
(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;

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V 366	Continued From page 17 (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 responses to level II incidents affecting 1 of 3 clients (#2). The findings are: Review on 8/22/23 of Incident Response Improvement System (IRIS) from July 1, 2023-August 22, 2023 revealed: - No IRIS report, Risk Cause/Analysis, or documentation to support submission of the written preliminary findings of fact to the Local Management Entity (LME)/ Managed Care Organization (MCO) within 5 working days for client #2 going AWOL (absent without leave) from the home and the police were called on 8/1/23. Interview on 8/22/23 with the Executive Director revealed: -Responsible for completing IRIS reports; -There was no IRIS report due to not knowing the police were called for the incident on 8/1/23.	V 366		