STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL090-217	A. BUILDING: _____ B. WING _____	R-C 02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES COTTAGE	1915 HASTY ROAD, SUITE F MARSHVILLE, NC 28103

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 2-1-24. Two complaints were substantiated (#NC00210215, #NC00210640) and one complaint was unsubstantiated (#NC00211660). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment For Children Or Adolescents. This facility is licensed for 12 and currently has a census of 6. The survey sample consisted of audits of 3 current clients. This survey originally closed on 12-5-23 but was reopened on 12-18-23 and 1-8-24 due to additional complaints.	V 000		
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	V 112		

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V 112	Continued From page 1 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 strategies to address the needs of 1 of 3 audited clients, (client #1). The findings are: Review on 11-28-23 of client #1's record revealed: -Date of admission: 3-31-23. -Age: 9. -Diagnoses: Disruptive Mood Dysregulation, Posttraumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, combined presentation. -Admission Assessment dated 12-5-22 which documented a history of client # 1 leaving while parents were asleep and leaving the home without permission. -Person Centered Plan (PCP) dated 12-6-22 and updated on 9-6-23 to add the following goal: "[Client #1] will stay within staff supervision and refrain from elopement to increase safety 7 out of 7 days a week." Review on 11-28-23 and 1-16-24 of the facility's incident reports for the period of 10-1-23 to	V 112		

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V 112	Continued From page 2 1-15-24 revealed: -11-4-23 client #1 eloped from facility grounds. -11-7-23 attempted to elope from facility grounds. -10-12-23 eloped from facility grounds. -12-24-23 eloped from facility grounds. -1-13-24 eloped from facility grounds. Interview on 1-9-24 and 1-16-24 with the Chief Clinical Performance Officer revealed: -Client #1 is a "frequent runner." -Client #1 likes to play "hide and seek" (going out of staff supervision) with the staff. "He thinks it's a game." -"He goes out of staff supervision on a daily basis, at least 3 to 5 times a shift." -"[Client #1] did really well when he first got here. But when he started eloping, now it's like one every other week." -"[Client #1] will not run by himself, so we try to keep him away from other kids he can talk into running with him. We tried giving him a one on one staff but he will go out of supervision even with the one on one staff." -Client #1's elopements were discussed during his team meetings. -"Our protocol regarding elopements (after a client has eloped) is that we look at each one on a case by case basis. We look at the individual child and try to process why they are running and put things in place to prevent the child from running. -There were no updates to client #1's PCP addressing the increase in elopements. -Written strategies were not implemented to address client #1 going out of staff supervion or his elopement from the facility.	V 112		
V 114	27G .0207 Emergency Plans and Supplies	V 114		

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V 114	Continued From page 3 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record reviews and interviews the facilty failed to ensure fire and disaster drills were conducted quarterly on each shift. The findings are: Review on 11-28-23 of the facility's fire and disaster drill log for March 1, 2023 to November 28, 2023 revealed: -No documentation of 1st shift (7 am to 3 pm), 2nd shift (3 pm to 11 pm), or 3rd shift (11 pm to 7 am) fire and disaster drills for the 2nd quarter (April, May, or June) of 2023. -No documentation of 1st shift fire or disaster drill for 3rd quarter (July, August, September) of 2023. Interview on 11-29-23 and 12-18-23 with client #1 revealed: -"We did one (a fire drill) a long time ago." - "No", Never practiced a disaster drill. -"I would get out....I would jump out the window."	V 114		

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V 114	Continued From page 4 Interview on 11-29-23 and 12-18-23 with client #2 revealed: -Had not completed a fire or disaster drill since coming to the facility. -"I would go out the door where the fire wasn't" Interview on 11-29-23 and 12-18-23 with client #3 revealed: -Had not completed a fire or disaster drill since he had been at the facility. -"I would get out of the house." -He would get out through a door. Interview on 12-1-23 with staff #3 revealed: -Worked 3rd shift. -"I think they (staff) have done some drills but not on my shift." Interview on 11-29-23 with the Chief Quality Improvement Specialist revealed: -No documentation of drills available for review period (March 1, 2023 to November 28, 2023).	V 114		
V 318	13O .0102 HCPR - 24 Hour Reporting 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL 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).	V 318		

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V 318	Continued From page 5	V 318		

This Rule is not met as evidenced by:
Based on record reviews and interview, the facility failed to notify the Health Care Personnel Registry (HCPR) within 24-hours of learning about allegations of abuse. Affecting 1 of 3 audited staff (FS #2). The findings are:

Review on 11-29-23 of staff #2's record revealed:
-Date of hire: 1-3-23.
-Residential Care Worker.

Review on 11-28-23 and 11-29-23 of the facility's incident and accident report log for September 1, 2023 to November 27, 2023 revealed:
-11-20-23 incident of staff #2 holding client #2's arm and telling client #5 to "get him" and allowing client #5 to kick client #2 in the stomach.

Review on 11-28-23 of the facility's Internal Investigation Report dated 11-22-23 revealed.
-Internal investigation initiated on 11-20-23.
-Staff #2 was placed on administrative leave on 11-20-23.
-Internal investigation was completed on 11-28-23. Staff #2 was terminated effective 11-28-23.

Review on 11-28-23 of the North Carolina Incident Response improvement System (IRIS) revealed:
-11-20-23 incident involving staff #2 was reported to HCPR on 11-27-23.

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V 318	Continued From page 6 Interview on 12-1-23 with the Chief Quality Improvement Specialist revealed: -The 11-20-23 incident was entered into IRIS on 11-27-23. -"The staff that completed the form (the IRIS report) didn't click the abuse, neglect or exploitation button in IRIS so the system didn't trigger the HCPR part." -The HCPR report was made on 11-27-23.	V 318		