Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED	
			A. BOILDING.				
		MHL051-225	B. WING		01/3	30/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
70 WEST 9421 US 70 BUSINESS WEST CLAYTON, NC 27520							
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)	
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETE DATE	
V 000	V 000 INITIAL COMMENTS		V 000				
	An annual and complaint survey was completed on 1/30/24. The complaint was substantiated (Intake #NC00212205). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children and Adolescents.						
		sed for 4 and currently has a urvey sample consisted of clients.					
V 132	G.S. 131E-256(G) Allegations, & Prote		V 132				
	G.S. §131E-256 HE REGISTRY (g) Health care faci Department is notif health care person unknown source, wany act listed in sub (which includes: a. Neglect or abustacility or a person as defined by G.S. as defined by G.S. b. Misappropriatio in a health care factory (b) of this section in care services as dehospice services as are being provided or Misappropriatio healthcare facility. d. Diversion of drufacility or to a patient of the section of drufacility or to a patient of the section of drufacility or to a patient of the section of drufacility or to a patient of the section of drufacility or to a patient of the section of drufacility or to a patient of the section of drufacility or to a patient of the section of drufacility or to a patient of the section of drufacility or to a patient of the section of drufacility or to a patient of the section	lities shall ensure that the lied of all allegations against hel, including injuries of which appear to be related to odivision (a)(1) of this section. See of a resident in a healthcare to whom home care services 131E-136 or hospice services 131E-201 are being provided. In of the property of a resident ility, as defined in subsection including places where home effined by G.S. 131E-136 or is defined by G.S. 131E-201 and the property of a light of the property of the					

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

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		E SURVEY PLETED
		MHL051-225	B. WING		01/	30/2024
	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
70 WES	Г		, NC 27520			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 132	a patient or client for providing services). Facilities must hav acts are investigate to protect residents investigation is in prinvestigations must	e evidence that all alleged d and must make every effort from harm while the rogress. The results of all be reported to the five working days of the initial	V 132			
	failed to ensure an reported to the Hea (HCPR) within 5 wo Review on 1/22/24 - Employed: 8/4/2 - Title: Paraprofe Review on 1/22/24 - Admitted: 3/13/2 - Age: 17 years of Diagnoses: Aut Intellectual Disabilit Anxiety, Conduct D	view and interview, the facility allegation of abuse was alth Care Personnel Registry orking days. The findings are: of Staff #2's record revealed: 22 assional of Client #1's record revealed: 23				

Division of Health Service Regulation

STATE FORM 6899 S70P11 If continuation sheet 2 of 4

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
		MIII 054 005	B. WING		04/0	0/0004	
		MHL051-225	B. WING		01/3	0/2024	
				STATE, ZIP CODE			
70 WEST	ī		0 BUSINES , NC 27520	SWEST			
0(4) ID	CLIMMA DV CTA		-			()/5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETE DATE	
V 132	Continued From page 2		V 132				
	Attention Deficit Hy	peractivity Disorder by History					
	Review on 1/24/24 of the Facility's Investigative Report revealed: - "On 1/12/24 [the Qualified Profession (QP)] during debriefing Client #1 alleged that Staff #1 slammed him to the ground" Review on 1/19/24 of the Incident Response Improvement System (IRIS) revealed: - No allegations against health care personnel reported						
	He had been at months[Staff #2] "jacket the floor"	4 Client #1 reported: the facility for about 10 ed me up and slammed me to on the floor, staff #2 grabbed					
	a paraprofessional - He did IRIS repreported to HCPR - He was notified didn't find out about until Child Protectiv - He did not notif know that he had to didn't happen - Stated that most that HCPR was not happened or not"	er of the facility but working as orts and would be the one that of the incident 1/11/24 but anyone being "slammed" e Services came out" y HCPR because he didn't o notify them if the incident ving forward, he would be sure ified whether "something					
	Interview on 1/22/24 - She didn't repo						

Division of Health Service Regulation STATE FORM

6899 S7OP11 If continuation sheet 3 of 4

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) I		(X3) DATE COMP) DATE SURVEY COMPLETED		
			A. BOILBING.					
		MHL051-225	B. WING		01/3	0/2024		
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
70 WEST	70 WEST 9421 US 70 BUSINESS WEST CLAYTON, NC 27520							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE		
V 132	- HCPR was not	4 the Director reported:	V 132					

6899

Division of Health Service Regulation STATE FORM

S70P11 If continuation sheet 4 of 4