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	MHL0601048	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on February 23, 2024. The complaint was substantiated (intake #NC00211742 and #NC00211809). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secured for Children and Adolescents. This facility is licensed for 4 and currently has a census of 3. The survey sample consisted of audits of 2 current clients and 1 former client.	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 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	V 112		

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V 112	Continued From page 1 obtained. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement strategies to address the needs of 1 of 1 audited former clients, (FC #3). The findings are: Review on 1/18/24 of FC #3's record revealed: -Admission date of 10/9/23. -Discharge date of 1/5/24. -Age [redacted] -Diagnoses of [redacted] - Admission Assessment dated 10/8/23: FC #3 had a history of aggressive behaviors, elopement, recurrent anger outbursts, physical aggression, problems in school and trouble getting along with his peers. FC #3 was sent to a juvenile detention center on 6/8/22 due to his physically aggressive behavior. -The Comprehensive Clinical Assessment (CCA) dated 10/8/23: "We are requesting a One on One to assist with [FC #3] to help with controlling his anger outbursts, constant threatening staff and other consumers." -Treatment plan dated 11/8/23: "[FC #3] has struggled to control his tantrums and explosive episodes 4 out of 7 days per week. [FC #3]	V 112		

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displayed challenging behavior and verbal aggression towards staff when being prompted or redirected... [FC #3] has displayed some difficulty with following directions 4 out of 7 days per week. [FC #3] has displayed verbal aggression consistently towards his staff and peers. Residential Treatment Level III will: Staff will provide 24/7/365 supervision, teaching of coaching skills and anger management skills, one on one support staff, link to other identified services by the CFT (Child Family Team)..."

Review on 1/18/24 of an incident report dated 1/5/24 submitted to the NC Incident Response Improvement System revealed:
-"...At approximately 6:50pm, One-on-one staff [Deceased Staff (DS)/ Associate Professional (AP) #5] allowed Consumer [FC #3] to make a phone call to his mother, but he informed Consumer [FC #3] that he would only have 10 minutes instead of 15 minutes due to phone hours ending. Consumer [FC #3] initially agreed to the time constraints but became upset once [DS/AP #5] reminded him of his 1 min (minute) warning to finish up with conversation. Consumer [FC #3] became upset and begin to curse out his staff before walking out of the home. Consumer [FC #3] was AWOL (absent without leave) for less than 5 minutes before re-entering the home. [DS/AP #5] informed Consumer [FC #3] that he would need to be searched upon re-entry into the home. Consumer [FC #3] refused to be searched and informed [DS/AP #5] that he could not tell him when to get off the phone with his mother and continued cursing at staff. Consumer [FC #3] attempted to call his mother again before attacking [DS/AP #5] by punching him in the face several times. [DS/AP #5] restrained Consumer [FC #3] using NCI+ (Nonviolent Crisis Intervention) Prevention for approximately 3-5

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minutes before releasing him. Consumer [FC #3] appeared calmed, but once he was released he continued to try to attack [DS/AP #5]. [DS/AP #5] used blocks to avoid strikes from Consumer [FC #3]. [DS/AP #5] attempted to walk to the office from the living room at which a time he tripped over the couch and fell to the floor. Consumer [FC #3] continued to hit staff with a closed fist and stomped on his head repeatedly. [Staff #1] attempted to intervene as Consumer [FC #3] turned his attention to other consumers making verbal threats. [DS/AP #5] was able to get up from the floor and walk to the office. [DS/AP #5] attempted to call 9-11 (911) Consumer [FC #3] followed him into the office and took the phone from staff and smashed his phone. Consumer [FC #3] then continued to attack [DS/AP #5] with direct blows to the face and head. [DS/AP #5] lost his balance fell to the floor again. Consumer [FC #3] continued to stomp [DS/AP #5] in the head while [staff #1] attempted to intervene. [Staff #1] placed a second call to 911. With the possibility of [DS/AP #5] potentially being unconscious at this time, Consumer [FC #3] dragged [DS/AP #5] out of the home and down the steps into the grass where he self-pronounced [DS/AP #5] dead yelling out gang verbiage related to being a [gang member]. At that time [Qualified Professional #2], pulled back up at the facility to find [DS/AP #5] on the ground grasping for air. [QP #2] called 911 and begin to administer CPR (cardiopulmonary resuscitation) until medics arrived."

Review on 1/18/24 of the Local Police Officer's narrative report dated 1/4/24 revealed:
-"Victim: [DS/AP #5] and Suspect: [FC #3]. "On 01-04-2024 at approximately 1925 hrs (7:25 pm) I, [Police Officer], was dispatched to a report of the victim of an assault not breathing at [facility's address]. The assault had previously been

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dispatched to other officers and I was added on when the status of the victim was updated.

I arrived on the scene and located the victim later identified as [DS/AP #5], laying in the front of the residence (facility) on the ground. [DS/AP #5] was not breathing and received CPR from medics and CFD (local fire department) crews. While [DS/AP #5] was being treated, I spoke to another employee (staff unknown) at the group home. I was advised that the suspect, [FC #3] had assaulted [DS/AP #5] repeatedly over a prolonged period of time and fled on foot north on Swearingan Ridge Court. I was provided clothing description, name and physical description of the suspect which I relayed to responding units. I was advised that [FC#3] was a resident (client) of the address, which is a group home for juveniles.

I spoke to another employee [Staff #1] as well as the other juvenile residents of the house. I was advised that [FC #3] had assaulted [DS/AP #5] repeatedly beginning in the living room of the residence. The assault continued through the residence from the living room to an adjacent room and then to the office according to the initial statements of the juveniles. Inside the house there was blood spatter from the incident throughout the living room, kitchen area and office area.

The juveniles were removed from the residence and separated for interviews by later arriving officers. The house (facility) was secured as well. K9 (police dog) arrived on scene and conducted a track through the neighborhood. [FC #3] was not located during the track.

At 2002 (8:02 pm) hrs [the medic staff] (Medic #10349) pronounced the victim (DS/AP #5)

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V 112	Continued From page 5 deceased and CPR efforts were haulted. The ambulance on scene was Medic 50. Homicide and CSS (Community Support Services) were notified. Officers transferred the juveniles (Client #1, Client #2, and Client #4) voluntarily to the LEC (Law Enforcement Center] to be interviewed by detectives from Homicide. [FC #3] returned to the scene and was detained by officers and transported to the LEC. When he approached the scene, he was wearing the same clothes as when he fled the scene. There was blood on his clothing and hands. Homicide detectives and CSS responded and processed the incident scene. CDCP (Child Development- Community Policing) and CPS (Child Protective Service) referrals were completed. The proper contact for each juvenile was unknown as they were residents of the group home at the incident location. For reporting purposes another previously documented employee of the group home was listed. Nothing further at this time." Review on 2/2/24 of video footage with audio of the facility dated "20240104" (01/04/2024) revealed: -Staff #1 and DS/AP #5 were the only two staff at the facility. -There were 4 clients present. -FC #3 became upset because the DS/AP #5 advised him telephone time was ending. -6:55 pm: The conflict over phone time started with the DS/AP #5 and FC #3.	V 112		

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6:59 pm: DS/AP #5 called an unknown female staff (could not identify staff's voice) and said, "[FC #3] is starting with me."
7:02 pm: DS/AP #5 had the unknown female staff on speaker phone (could not identify staff's voice), and she was trying to calm FC #3 down.
7:03 pm: The unknown female staff was still on speaker phone saying something when FC #3 started punching the DS/AP #5 in the head and face repeatedly. Staff #1 was sitting on the couch watching and did not move. Client #1 tried to get FC #3 off DS/AP #5.
7:04 pm: DS/AP #5 broke away from FC #3 and went to the staff office.
7:05 pm: The facility telephone rang, and Staff #1 answered. DS/AP #5 got his cellphone and tried to call the police, but a computerized voice can be heard saying, "Would you like me to hang up?".
7:07 pm: FC #3 grabbed DS/AP #5's cellphone, smashed it on the floor and began punching him repeatedly in the face and head. DS/AP #5 fell to the floor and FC #3 punched and kicked him in the face and head repeatedly.
7:08 pm: FC #3 stopped attacking DS/AP #5 and DS/AP #5 was able to get back up, but was unsteady on his feet.
7:09 pm: FC #3 started punching DS/AP #5 in the face and head repeatedly again. FC #3 continuously punched and kicked DS/AP #5 until he fell to the floor unconscious. While DS/AP #5 was unconscious on the floor, FC #3 repeatedly stomped on DS/AP #5's head and neck area and punched him in the head repeatedly.
7:11 pm: FC #3 stopped and walked outside. Client #2 went to check on DS/AP #5 when FC #3 burst back in the facility and told Client #2 to leave him (DS/AP #5) alone. One of the clients can be heard saying, "Leave him alone." In a whimpering voice as FC #3 dragged the DS/AP

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V 112	Continued From page 7 #5's body outside into the front yard and assaulted DS/AP #5 again by punching and stomping him in the head and face. 7:12 pm: Staff #1 called the Executive Director. 7:13 pm- 7:14 pm: FC #3 stopped the attack on DS/AP #5 and came back into the facility and started looking through drawers in the staff office. Staff #1 looked out the door at DS/AP #5 and dialed a number on her phone. Client #2 was wiping blood off the floor in the staff office and kitchen. 7:14 pm: Staff #1 told the other clients the Executive Director was on her way and went back outside with the DS/AP #5 and FC #3. 7:20 pm: Client #4 could be heard saying, "QP #2 is here" Interview on 2/8/24 with Client #1 revealed: -"I don't want to talk about this anymore." Attempted interview on 2/1/24 with Client #2 was unsuccessful due to Client #2's guardian not giving consent to speak to Client #2. Interview on 2/1/24 with Client #2's Guardian revealed: -"I don't think it would be a good idea to ask [Client #2] about the attack that killed that staff (DS/AP #5)." -"He (Client #2) is showing signs of trauma after witnessing the deadly attack at the facility." Attempted interview on 2/15/24 with FC #3 was unsuccessful due to him declining to be interviewed. Attempted interview on 2/8/24 with Client #4 was unsuccessful due to him declining to be interviewed.	V 112		

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V 112	Continued From page 8 Interview on 1/30/24 with Staff #1 revealed: -Hired 1/3/24. -1/4/24 was her first day of training at the facility. -She arrived at the facility at approximately 4pm. -"I was told there would be two guys there to train me, but when I got there it was only one (DS/AP #5)." -DS/AP #5 told her that QP #2 had went to the store but was coming back to the facility. -FC #3 asked to use the telephone to call his mom and DS/AP #5 agreed but told FC #3 he only had 10 minutes. -FC #3 became agitated while on the telephone and DS/AP #5 advised him telephone time was ending. -FC #3 ended his call and became upset with DS/AP #5 for telling him telephone time was over. -"[DS/AP #5] called [QP #2] on speaker phone, and told her [FC #3] was acting up. [QP #2] tried to calm him (FC #3) down. " -FC #3 started punching the DS/AP #5 in the face and head repeatedly. -FC #3 stopped striking the DS/AP #5 and DS/AP #5 went to get the telephone from the office to call the police. -She did not call the police initially because DS/AP #5 said he was going to call. -FC #3 went to the office behind DS/AP #5, grabbed the telephone and smashed it on the floor. -FC #3 attacked DS/AP #5 for a second time by punching him in the face and head. -She called the police after the second attack. -She called the Executive Director and told her FC #3 was "beating" the DS/AP #5. -The Executive Director told her to call the police and stay with the other clients. -She tried to talk to FC #3 and process with him to get him to calm down. -"He [FC #3] was in a rage. [DS/AP #5] never	V 112		

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even touched him."
-FC #3 attacked DS/AP #5 for a third time, punching him repeatedly in the face and head, and stomping on his face and neck until he was unconscious.
-She called the police again and called QP #2 to see why it was taking her so long to get to the facility.
-DS/AP #5 was unconscious when FC #3 dragged him outside and continued the attack.
-QP #2 arrived after approximately 30 minutes.
-FC #3 ran off down the street when QP #2 arrived.
-The neighbors called the police again.
-QP #2 did CPR on DS/AP #5 until the paramedics arrived and pronounced him deceased.
-FC #3 returned to the facility when police arrived.
-"I didn't know he [FC #3] was supposed to have one on one staff support. It was my first day of training."
-"I don't know the staffing requirements."
-Did not know who was responsible for making the schedule.

Interview on 1/30/24 with QP #2 revealed:
-She was the on call staff on 1/4/24.
-Staff #4 and DS/AP #5 were supposed to be training Staff #1.
-Staff #4 called out before his shift and she agreed to cover his shift.
-"When I got there, we decided to have a movie night for the clients, so I went to the store down the street to get movie snacks."
-Could not remember what time she got to the facility.
-"I can't remember what time I got there, I know it wasn't dark yet."
-"I was gone for about 15 minutes when [DS/AP #5] called me and asked me what time I was

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coming back because [FC #3] was having a behavior. I could hear [FC #3] yelling in the background."
-Told DS/AP #5 she would be back to the facility shortly.
-After about 20-25 minutes Staff #1 called her "hysterical" saying [FC #3] had attacked DS/AP #5.
-When she arrived at the facility DS/AP #5 was laying in the yard of the facility, gasping for air.
-Could not remember what time she got back to the facility from the store.
-She did CPR on DS/AP #5 until the paramedics arrived and took over.
-"[FC #3] had one on one support staff."
-FC #3's one on one staff was usually her, DS/AP #5 or Staff #4.
-DS/AP #5 was responsible for making the schedule and the Executive Director would oversee the schedule.
-"It was usually three staff on every shift."

Interview on 2/15/24 with Staff #4 revealed:
-Was supposed to help DS/AP #5 train Staff #1.
-Called on call staff (QP #2) to call out an hour before his shift.
-The on call staff (QP #2) was responsible for finding someone to cover his shift.
-DS/AP #5 and Executive Director was responsible for making the schedule.
-"It was usually 2 or 3 people on each shift."
-"[FC #3] had a one on one."

Interview on 1/30/24 with the QP #3 revealed:
-Completed FC #3's admission assessment.
-Responsible for FC #3's treatment plan.
-FC #3 was supposed to have one on one staff support.
-Did not know who made the schedule for the facility.

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V 112	Continued From page 11 Interview on 2/8/24 with Executive Director revealed: -Was not aware DS/AP #5 was at the facility alone training Staff #1 on 1/4/24. -"[Staff #1] called and told me [FC #3] was beating [DS/AP #5], but she never told me no other staff was there." -Was not aware Staff #4 called out on 1/4/24 until 1/5/24 when she started the internal investigation. -QP #2 was responsible for finding someone to cover Staff #4's shift because she was the on-call staff on 1/4/24. -"[DS/AP #5] made the schedule for Swearingan and I would help him with it if he needed it." -"[FC #3] had one on one staff support as recommended, but he did not like for us (staff) to call it one on one support." -"Sometimes it was 3 staff on a shift due to staffing." -"There was 3 staff working sometimes, but at least 2." -Not aware there was supposed to be 3 staff present in order to provide one to one support services for FC #3. -"I'm working on hiring and training new staff , and working with the QPs so this does not happen again." Review on 2/22/24 of the Plan of Protection dated 2/22/24 completed by the Executive Director revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? Miracle Houses Clinical Staff will continue to ensure ongoing trainings and weekly meetings with the Clinical Director for all Qualified Professionals to ensure that each consumer has strategies implemented in their Person Centered Plan to meet their individualized goals. The	V 112		

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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 112	Continued From page 12 Clinical and the clinical team will will review the Clinical Comprehensive Assessment (CCA) and Crisis Plan to determine the strategies and interventions to implement in the plan for one- on-one support for each child. Describe your plans to make sure the above happens. Prior to admitting consumers, the Clinical team will assess each individuals needs by completing the pre-screening form. Which will be based on the Clinical Comprehensive Assessment (CCA) recommendations. Following the CCA, the clinical team will determine if the consumer requires one-on- one support to ensure their safety as well as that of their peers and staff. The QP will meet with the one- on one and the entire staff team at the facility to roll -out the consumers treatment plan. Once the Person Centered Plan (PCP) and Crisis Plan have been reviewed by the Clinical Director and Qualified Professional (QP) doing admission, if strategies outlined in the PCP are not meeting criteria according to the CCA the clinical will add additional strategies immediately. The QP and the staff will ensure the strategies are implemented in their daily activities and treatment to ensure they achieve their goals and provide safety. In January 2024, Miracle Houses Inc. QPs received a certificate of completion from UNC School of Social Work on Person Centered Plan. Miracle Houses Inc. will continue to hold weekly clinical meetings to ensure the strategies are effective for consumers and to revise them as needed. The QP will discuss the progress in the Family and Child Team Meeting to continue person centered plan."	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601048	A. BUILDING: _____ B. WING _____	R-C 02/23/2024

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V 112	Continued From page 13 FC #3 had diagnoses including [redacted] He had a history of aggressive behaviors, elopement, recurrent anger outbursts, physical aggression, problems in school and trouble getting along with his peers. FC #3's Clinical Comprehensive Assessment indicated the need for one on one staff support for help controlling his anger outbursts and constant threatening of staff and other consumers. FC #3's treatment plan included treatment strategy of one on one staff supervision on 1/4/24 during which time FC#3 became upset with DS/AP #5 when he was advised his telephone time was ending. FC#3 started punching the DS/AP #5 in the head and face repeatedly. FC #3 continuously punched and kicked DS/AP #5 until he fell to the floor unconscious. While DS/AP #5 was unconscious on the floor, FC #3 repeatedly stomped on DS/AP #5's head and neck area and punched him in the head repeatedly. FC #3 dragged the DS/AP#5's body outside into the front yard and assaulted DS/AP #5 again by punching and stomping him in the head and face. Other staff did not intervene to stop attack. DS/AP #5 was pronounced deceased by Medic at 8:02pm. This deficiency constitutes constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 112		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be	V 736		

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V 736	Continued From page 14 maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility was not maintained in an attractive manner. The findings are: Observation on 1/29/24 at 12:53 pm of the facility revealed: -Broken toilet tissue holder which exposed a sharp metal hook in the clients' shared bathroom. -There were 2 missing drawer faces in the kitchen which exposed wood and nails. -The window blinds in Client # 1's room was missing 1 slat and 3 slats were broken in half. Interview on with QP #2 revealed: -"I hadn't noticed the broken issue holder." -"The clients mess the blinds up all the time." -Executive Director was responsible for repairs to the facility. Interview on with the Executive Director revealed: -She rented the facility. -She has asked the property's owner to make repairs. -She would find a repair man to make repairs at the facility. This deficiency constitutes a re-cited deficiency and must be corrected in 30 days.	V 736		