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By Pamela S. Pridgen at 8:04 pm, Mar 25, 2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-352	A. BUILDING: _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIDGE	2442 SANDHURST COURT GASTONIA, NC 28054

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V 000	INITIAL COMMENTS An annual and follow up survey was completed on 2-26-24. 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 4. The survey sample consisted of audits of 3 current clients.	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 obtained.	V 112	When receiving referrals for prospective consumers, the treatment team will meet to review all clinical documents and address the needs of the consumer. The consumer will be interviewed with their current provider and/or team. Bliss Haven's treatment team will meet & develop a plan for the consumer that includes but limited to long term goals, short term goals interventions & time frames. The treatment with continue to meet every thirty days or as needed should the developed plan need to be revised. The QP will continue to update the PCP every thirty days or as needed as the therapist will continue to update the CCA every thirty days or as needed.	

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to develop and implement strategies and goals in the client's treatment plan to address the needs of the client affecting 1 of 3 audited clients (client #1). The findings are:

Review on 2-1-24 of client #1's record revealed:
-Date of admission: 8-14-23.
-Age: 11.
-Diagnoses: Attention Deficit Hyperactivity Disorder, Predominately Hyperactive type, Adjustment Disorder with Anxiety.
-Person Centered Plan dated 1-12-2024 documented the following:
"Daily Life and Employment" Domain: [Client #1] has trouble with physical aggression and verbal aggression, and appropriate emotional expression. Social and Spirituality Domain: [Client #1 struggles with healthy communication and appropriately resolves conflict with her peers in the level lll residential group home."
-"Short term goal 1: The client will develop and implement coping skills to reduce episodes of anxiety 6/7 days out of the week."
a) 11-16-23 update: "The client struggles with this goal, as she does not utilize any coping skills or allow assistance to regulate when she is in crisis."
b) 1-12-14 update to plan: "The placement reports the client refuses to utilize any coping

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mechanisms and will not accept assistance from staff. The placement reports the client is extremely disrespectful and defiant towards staff.
-"Short term goal 2: The client will implement and maintain healthy boundaries between peers and staff with evidence of no physical altercations or invading others' space 6/7 days of week."
a) 11-16-23 update: "The client has struggled with this goal tremendously, as she has hit staff, attempted to stab staff, bite and spit staff (spit on) on more than one occasion. The client is extremely defiant and aggressive daily."
b) 1-12-24 update: "The placement reports the client struggles with maintaining boundaries with staff and peers, physically and verbally. The placement reports the client continues to show her aggression and defiance towards staff when prompted or directed to complete a task."
-"Short term goal 3: The client will comply with level lll group home rules and regulations with evidence of medication compliance and therapy engagement."
a) 11-16-23 update: "The client struggles to engage in therapy nor does she follow the bedtime routine."
b) 1-12-24 update: "The placement reports the client is extremely defiant and disrespectful towards specific staff. The client will not engage in therapy nor follow any of the routines expected in the placement."
-No documentation of updated strategies or goals to address client's cursing, hitting, spiting on staff, or property destruction.

Observation of the facility on 1-31-24 (3 pm) and 2-1-24 between 2:30 pm and 3:30 pm revealed:
-Kitchen island with 3 cabinet doors missing the middle door.
-A hole approximately 2 to 3 inches wide in the wall of client #1's bedroom.

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V 112	Continued From page 3 Interview on 2-7-24 with staff #1 revealed: -"[Client #1] has behaviors every day. She's just that type of kid. No matter what you do she's just [Client #1]." -"She'll cuss you out, spit on you, hit you, throw things at you. [Client #1's] problem is 'No', if you say no to her that kid goes from a level 0 to 1,000 in 2 seconds. She is destructive (ripped the door off a cabinet, kicked a hole in her bedroom wall), she raises h**l (cursing at staff, hitting staff, spiting on staff) all day. It's not just me, it's everybody. No one else wants to work with her." -No documented strategies that she is aware of. "We (staff) just have to process with her through her behaviors if that doesn't work we call [Executive Director (ED)]. It's unreal (client #1's behaviors). She needs a higher level of care." Interview on 2-1-24 with Staff #3 revealed: -"She's (client #1) acting out (having behaviors) all the time. She will have a behavior (cursing staff, hitting staff, throwing chairs at staff) 6 out of 7 days." -"That's just [Client #1], that's just who she is." -Not aware of any documented strategies to address client #1's behaviors. Interview on 1-31-24 and 2-1-24 with the ED revealed: -"[Client #1] started having behaviors about two weeks after she was admitted. Her behaviors are daily. I am getting calls every day about [client #1]." -"I'm getting called almost every morning, you should see my phone bill. She (client #1) is refusing to get up, she's refusing to take her shower and get ready for school. They call me and I have to talk to her. Usually the conversation goes something like what's wrong?,	V 112		

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V 112	Continued From page 4 you know you have to do this or that. I'll tell her if she does whatever (what she is refusing to do) I will take her to [local dollar store] or something like that and she will comply." -"Look at this, (condition of the home), doors ripped off, holes in the wall. We never had this before she came." -"I'm on the phone daily with her social worker discussing [client #1's] behavior." -Sees her therapist weekly. "She (client #1) doesn't really participate with the therapy sessions. He attention span is really short. She has to be continually prompted to pay attention to the therapist and then she will just get up and ignore the therapist. I'll walk in the room and the therapist will be talking to a blank screen and [client #1 will be doing something else." -"I've lost staff, staff have quit because of her, they are getting beat up, hit, cussed out. -"She (client #1) does not like to be told no, I don't care what it is, if you tell her no it sets her off. She is oppositional any time she is asked to do something she does not want to do." -"We (provider) gave her a 30 day notice (discharge) in December (2023), but nobody would take her because of her age and her behaviors. I believe that every child deserves a chance, I'm not going to kick her out." -There is no documented plan to address client #1's behaviors. "We (provider) have just been taking it day by day." -No new strategies or goals developed or implemented to address client#1's needs. -"The plan is the staff calls me and I talk to her and process with her." This deficiency is cross referenced into 10A NCAC 27G .1701 Scope V(293) for a Type B rule violation and must be corrected within 45 days.	V 112		

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V 131	Continued From page 5	V 131		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure that a Health Care Personnel Registry (HCPR) check was completed prior to an offer of employment for 2 of 3 audited staff (staff #1 and #3). The findings are: Review on 2-1-24 of Staff #1's record revealed: -Date of hire: 3-24-23. -Job title: Direct Care Worker. -HCPR check: 6-27-23. Review on 2-1-24 of staff #3's record revealed: -Date of hire: 12-11-23. -Job title: Direct Care Worker. -HCPR check: 2-1-24. Review on 2-1-24 of a computer printout dated Wednesday January 31, 9:41pm titled 'hcpr nc listing History" which the provider presented as evidence she had accessed the HCPR registry for staff #3, however there were no names or	V 131	After interviewing the candidate, the Executive Director will complete a background check as well as run a HCPR check on the candidate prior to job offer. Due to the HPCR not displaying the original date the check was completed, the Executive Director will keep a separate binder with copies of the HPCR check.	

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V 131	Continued From page 6 dates listed on the printout to document who the checks were completed for, or when the attempted checks were completed. Interview on 2-1-24 with the Executive Director revealed: -Both of the HCPR checks had been completed on staff #1 and staff #3 when they were hired. -"I spilled something on [staff #1's] paper when I was working on her file one day and had to re-do (reprint) hers. -"I'm not sure why [staff #3's] is not in her record. I know I did hers, it might be misfiled."	V 131		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client.	V 132		

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V 132	Continued From page 7 e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the Health Care Personnel Registry (HCPR) was notified of allegations against facility staff and provide evidence that the allegation was investigated affecting 1 of 3 audited staff (client #1). The findings are: Review on 2-1-24 of client #1's record revealed: -Date of admission: 8-14-23. -Age: 11. -Diagnoses: Attention Deficit Hyperactivity Disorder, Predominately Hyperactive type, Adjustment Disorder with Anxiety. Review on 2-1-24 and 2-9-24 of the facility's	V 132	As soon as the provider is notified of allegation(s) against the facility and/ or staff, the provider will complete an IRIS incident immediately as well as notify the the HCPR of the allegation(s) as well as document the internal investigation & submit it. The accused will be suspended & removed from the schedule immediately pending investigation Incident logbook will be checked weekly or as needed by the Executive Director and/or QP/AP. Staff will complete all internal incident reports before the end of their shift.	

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V 132	Continued From page 8 video footage revealed: -Due to the quality of the video the date and time stamp were unrecognizable. -Client #1 was standing around the dinning room table with an object in her hands, . Staff #3 was sitting in a chair between the dinning area and the kitchen island. Client #1 was hitting the table with the object. Staff #1 moved from the opposite side of the table towards client #1 and attempted to grab the object from client #1's hand. Client #1 and Staff #1 can be seen struggling over the object for approximately 10 seconds until staff #1 is able to pull the object from client #1's hands. Staff #1 walks away from client #1 and client #1 walks to the end of the table, picks up a chair and throws it against the wall. Client #1 walks to the kitchen island and began to talk in the direction of staff #1. There is no audio to the video however client #1 is flailing her arms, hitting her legs and hitting a chair that is positioned beside the island. Staff #1 is on the opposite side of the kitchen island and she and client #1 were talking back and forth to each other. Client #1 stepped up on the chair and sat down. Staff #1 came from the opposite side of the island and approached client #1. Staff #1 grabbed client #1 by front of her shirt near the neck area and pulled her from the chair to the floor. Client #1 got up from the floor and grabbed a chair and attempted to hit staff #1 with the chair at which time staff #3 intervened by grabbing the chair. Client #1 ran around staff #3, staff #1 followed her. Client #1 grabbed another chair with staff #1 also grabbing chair at the same time. Client #1 and staff #1 struggle for the chair until the video ends. Review on 1-31-24 of the facility's "Report of Refusals" (incident/accident reports) for November 1, 2023 through January 31, 2024 revealed:	V 132		

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V 132	Continued From page 9 -No documentation of an incident occuring on 1-22-24 of staff #1 pulling client #1 by her shirt off of a chair causing her to fall to the floor. Review on 1-31-24 of the North Carolina Incident Response Improvement System (IRIS) for November 1, 2023 through January 31, 2024 revealed: -No documentation of an incident occuring on 1-22-24 of staff #1 pulling client #1 by her shirt off of a chair causing her to fall to the floor. Review on 2-1-24 of a copy of an IRIS report submitted on 2-1-24 at 2:39 pm documenting the incident of staff #1 pulling client #1 by her shirt off of a chair causing her to fall to the floor. Interview on 1-31-24 and 2-1-24 with client #1 revealed: -"We came back from a long ride. I was trying to slice tomatoes and out of the blue she (staff #1) snatched the tomato out my hand and said you ain't getting tomatoes so I snatched it back out her hand. She picked me up by my arm and brung me in my room. She was pushing my head down and her knee was in my back. After I turned over her knee was right here (pointed to her chest area). My chest was hurting for one thing." -" First I kicked her cause she would not get off of me. She grabbed me by my shirt and she took me up to the sky and threw me to the other side of the room and that's when I hit the wall." -"She always threaten me. She say she gonna get me and stuff like that. She always grabs me and I don't like people grabbing on me she is spiteful." Interview on 2-7-24 with staff #1 revealed: -"We had just come home from an outing and we	V 132		

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were making subs for dinner. She (client #1) was already arguing with another client. She said [staff #1] 'I want to cut the tomato', I said wait till I get the knife. The real knives are put up, they (clients) have plastic knives. She got in the cabinet and got her plastic knife and was jugging in the tomato. Again I told her to wait and she got mad and threw the tomato at me. I told her to let's go to your room trying to get her to calm down but she was cussing and swinging and trying to throw chairs. That's when I grabbed her, I grabbed her by her arms and took her to her room. I sat her right at the door (bedroom door) and told her to calm down. She instantly got back up and came out cussing everybody out, telling me to get the d**n knife, she threw the tomato at me, she threw the paper towel thing at me."
-"None of that is true, that stuff about me moving her bed and saying I told her now we are off camera, that's not true. They (ED) said I pulled her down aggressively, well I don't know what y'all saw but that didn't happen."

Interview on 1-31-24 with staff #3 revealed:
-"...we were having subs..., [Client #1] said I'm cutting the tomatoes.'
-"One of her (client #1's) things is, I'm gonna do it she doesn't ask [Staff #1] said no you can't cut tomatoes cause you can't use the knife.' [Staff #1] asked [Client #1] to give her the tomatoes and she reached for the tomatoes and couldn't get the tomatoes from [Client #1]. One of the tomatoes came out the bag and [Client #1] started acting out. She slung the bag up in the air, she stomped around slinging stuff down. So much was happening all at once sometimes you can't get everything that is happening. [Staff #1] said come on [client #1] we are not going to have this let's go to your room.' [Client #1] refused to go to her room and they were in the hallway and she

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V 132	Continued From page 11 (staff #1) was asking [Client #1] multiple times to go to her room. [Client #1] was swinging at [Staff #1], she knocked [Staff #1's] glasses off her face. [Client #1] was scuffling with [Staff #1], [Staff #1] was not really scuffling with her. I was trying to keep an eye on the other kids so technically I didn't get to see everything that was happening. [Staff #1] picked her (client #1) up from under her arms and took her to her room. [Client #1] was cussing, 'you b***h leave me alone, I hate you.' She was crying." -"She (client #1) came back in (to the kitchen). I asked her if she was ready to eat and she was heavily crying and she said her stomach was hurting I told her maybe she was hungry she said no she (staff #1) hit me in my stomach and she threw me down. She was crying real hard. I thought maybe she was just saying something so I kept telling her she probably needed to just eat something and that that might be why her stomach maybe hurting. [Staff #1] came in the kitchen and they (client #1 and staff #1) were going back and forth with each other." -Did not see staff #1 pull client #1 off the chair. "I was watching the other kids." Interview with the ED on 1-31-24 revealed: -On 1-27-24 she became aware of the allegation that on 1-22-24 staff #1 grabbed client #1 by her shirt and pulled her off of a chair causing her to fall on the floor. -"I asked [staff #3] about the incident and spoke to [staff #1], [staff #1] denied the allegation. I looked at the camera footage. I couldn't see what happened in the bedroom but what I did see (in the kitchen) alarmed me. I went ahead and suspended her." -"I called DSS (Department of Social Services) and made a report to them on Monday (1-29-24). -"I thought I was following protocol by notifying	V 132		

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V 132	Continued From page 12 DSS. I've never had to to this, we have never had anything like this happen. I though that reporting to DSS was all we needed to do. I thought once we notified DSS they (DSS) would notify IRIS and HCPR."	V 132		
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 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	V 293		

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V 293	Continued From page 13 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 minimize the occurrence of behaviors related to functional deficits and provide active therapeutic treatment affecting 1 of 3 audited clients (client #1). The findings are: CROSS REFERENCE: 10A NCAC 27G .0205 Assessment And Treatment/Habilitation Or Service Plan (V112). Based on record reviews and interviews, the facility failed to develop and implement strategies and goals in the client's treatment plan to address the needs of the client affecting 1 of 3 audited clients (client #1). The findings are:	V 293		

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V 293	Continued From page 14 Review on 2-15-24 of the Plan of Protection dated 2-15-24 and written by the Executive Director (ED) revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? To ensure the safety of consumers in care of Bliss Haven Group Home (Licensee), staff will continue to be trained upon hire as well as continued trainings throughout their employment at Bliss Haven Group. Real incidents/situations will be assessed/discussed during scheduled & emergency team meetings. Staff will be trained to know what child abuse is, know the signs of child abuse/neglect, how to actively listen to the child & ensure that the child understands that he/she is heard & not to feel guilty of reporting the alleged abuse/neglect. Staff will also be trained on how to properly report abuse. The treatment team will come up with plan tailored to consumers prior to admission to the facility. Describe your plans to make sure the above happens. The Director will schedule necessary trainings with all staff within the next three weeks." Review on 2-20-24 the amended Plan of Protection dated 2-20-24 and written by the ED revealed: "A behavioral plan & protocol will be developed for the consumer & staff to help address & decrease behaviors. The treatment team will develop a plan for the consumer & update as needed until discharge date. If Bliss Haven observes that the plan isn ' t working for the consumer, the team will call an emergency CFT (child and family team) meeting to discuss new strategies & possibly include additional therapy as well as other programs/activities for at risk youth. If Bliss Haven Group has exhausted all	V 293		

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resources, services & or strategies & is not able to meet consumer ' s needs, Bliss Haven Group will proceed with the licensed therapist level of care recommendation & issue a 30-day notice. Bliss Haven will not keep the child at the residence past the 30th day despite DSS (department of Social Services) & the MCO (LME/Local Management Entity/Managed Care Organization) not being able to secure a placement for the consumer.
A 30-day notice was put in place on Thursday, February 15, 2024 for the consumer (client #1).
The Director has scheduled to meet with the treatment team weekly until the consumer ' s discharge date starting on February 26, 2024 at 8 AM to discuss strategies to help with treatment as well as decrease behaviors.
Staff will complete refresher trainings by March 8, 2024. Staff who do not attend the mandatory trainings will be removed from the schedule until trainings are complete.
Medication management will continue to be followed up every 30 days/as needed & requests for medication changes will take place."

Client #1 is 11 years old with diagnoses including Attention Deficit Hyperactivity Disorder, Anxiety, and Adjustment Disorder. Client #1 had experienced daily behaviors which included, property destruction (ripping a door off of a kitchen cabinet, kicking a hole in her bedroom wall) , verbal and physical aggression (cursing at staff, slapping staff in the face, throwing chairs at staff, spitting on staff) and non-compliance to house and program rules (refusing to follow a house schedule, refusing to complete hygiene routine, refusing to participate in therapy sessions). A 30 day discharge notice was issued for client #3 in December 2023, however the notice was resented due to her teams inability to

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V 293	Continued From page 16 secure appropriate placement due to client #1's age and behaviors. The facility failed to develop and implement strategies to address client #1's behaviors. This deficiency constitutes a Type B violation which is detrimental to the health, safety and welfare of the clients and must be corrected within 45 days.	V 293		
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). This Rule is not met as evidenced by: Based on record review 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. The findings are:	V 318	Provider will complete an IRIS incident report & notify the HPCR immediately of any abuse, harm and/or neglect. The staff was suspended immediately when the executive director was notified of the incident; Bliss Haven will continue to suspend any staff suspected of any abuse, harm or neglect until the investigation is complete.	

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V 318	Continued From page 17 Review on 2-1-24 of staff #1's record revealed: -Date of hire: 3-24-23. -Job title: Direct Care Worker. Review on 1-31-24 of the facility incident and accident reports revealed: -No documentation of an incident occuring on 1-20-24 of staff #1 pulling client #1 by her shirt off of a chair causing her to fall to the floor. Review on 1-31-24 of the North Carolina Incident Response Improvement System (IRIS) revealed: -No documentation of an incident occuring on 1-20-24 of staff #1 pulling client #1 by her shirt off of a chair causing her to fall to the floor. -No documentation of a 24-hour report to HCPR. Review on 2-1-24 of a copy of a IRIS report submitted on 2-1-24 at 2:39pm documenting the incident of staff #1 pulling client #1 by her shirt off of a chair causing her to fall to the floor. Interview with the ED on 1-31-24 revealed: -On 1-27-24 she became aware of the allegation that on 1-22-24 staff #1 grabbed client #1 by her shirt and pulled her off of a chair causing her to fall on the floor. -"I called DSS (Department of Social Services) and made a report to them on Monday (1-29-24). -"I thought I was following protocol by notifying DSS. I've never had to to this, we have never had anything like this happen. I though that reporting to DSS was all we needed to do. I thought once we notified DSS they (DSS) would notify IRIS and HCPR."	V 318		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT	V 366		

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V 366	Continued From page 18 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 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:	V 366		

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V 366	Continued From page 19 (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 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	V 366		

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V 366	Continued From page 20 (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; (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 interview, the facility failed to implement written policies governing their response to level I, II and III incidents. Affecting 3 of 3 audited clients (clients #1, #2 and #3). The findings are: Review on 1-31-24 of the facility's "Report of Refusals" (incident/accident reports) for November 1, 2023 through January 31, 2024 revealed: -No documentation of an incident occuring on 1-20-24 of staff #1 pulling client #1 by her shirt off of a chair causing her to fall to the floor. -No documentation regarding client #1's behaviors of property destruction, verbal or physical aggression to staff or peers. -No documentation of physical restraints for client's #1, client #2 or client #3.	V 366		

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V 366	Continued From page 21 Review on 1-31-24 of the North Carolina Incident Response Improvement System (IRIS) for November 1, 2024 through January 31, 2024 revealed: -No documentation of an incident occuring on 1-20-24 of staff #1 pulling client #1 by her shirt off of a chair causing her to fall to the floor. -No documentation regarding client #1's behaviors of property destruction, verbal or physical aggression to staff or peers. -No documentation of physical restraints for client's #1, client #2 or client #3. -No IRIS risk cause analysis or documentation to support submission of written preliminary findings of fact to the local Managed Care Entity (LME)/Managed Care Organization (MCO) within 5 working days of client being pulled by her shirt off of a chair into the floor on 1-22-24. Interview on 2-1-24 with client #1 revealed: -"Yes, I been restrained (dates unknown), maybe twice. Only when I be bad." Interview on 2-1-24 with client #2 revealed: -Don't know if she has been restrained since she has been here but has seen the other girls get restrained. -Cannot remember specific dates she witnessed the restraints. -"[Staff #1] restrained [client #1]." -Did not see the incident (staff #1 pulling client #1 by her shirt off of a chair causing her to fall to the floor). "I just saw her (staff #1) restraining her (client #1)." Interview on 2-1-24 with client #3 revealed: -She was restrained one time. -"Cause one time one staff (former staff/(FS) #4) bought me something (a toy) and I wanted to	V 366		

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keep the Spiderman thing on the top (of the toy) and she (FS #4) threw it away and I went in the trash can and tried to get it out and she keep taking it and she restrained me."
-"She (FS #4) grabbed my elbows and my elbows were back behind my back so I couldn't move."

Interview and observation on 2-1-24 at 3:04 pm with client #4 revealed:
-"[Staff #3] restrained me. Just once I was on the floor like that (demonstrates her position) and she put all her body weight on me. Then I spit on her and she put her arm around my neck (places her arm around her throat/neck area). It took about 5 hours."

Interview on 2-7-24 with staff #1 revealed:
-"Yes we do restraints."
-"[Client #1] has behaviors every day. She's just that type of kid. No matter what you do she's just [Client #1]."
-"She'll cuss you out, spit on you, hit you, throw things at you. [Client #1's] problem is No, if you say no to her that kid goes from a level 0 to 1,000 in 2 seconds. She is destructive (property damage), she raises hell all day."
-Documents behaviors on all the clients in the daily logs.

Interview on 2-1-24 with staff #3 revealed:
-"We are suppose to (use restraints) but I choose not to unless one of the kids become combative. We have not been properly exposed (trained) to restraints.
-"One of the kids was in a crisis and she was carrying on and picked up a chair and threw it at the other kids in the living room. I had to grab her by both of her wrist to make sure she didn't move. I made sure she was held until she calmed down it took her a long time to calm down she was real

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V 366	Continued From page 23 aggressive she actually spit in my face and I just had to hold her for like 5 minutes then I let her up." -Did not complete an incident report. Interview on 1-31-24 and 2-1-24 with the Executive Director (ED) revealed: -The house manager is responsible for completing the incident reports. -The house manager left "a couple of months" ago. -"When they (staff) call me and tell me about these behaviors I always ask them if they completed a incident report. The house manager was the one that was suppose to make sure the incident reports were completed and submitted and I think that's where things fell through the cracks with the incident reporting." -"I think too, staff are not using the correct language, we don't do restraints. When they call me about a restraint I have to correct them. I ask them was it really a restraint or were you just impeding movement? If you are stopping someone from running by standing in front of them, that's not a restraint or if you hold someone's arms to keep them from hurting you another child then that's not a restraint. I tell them (staff) they have to be careful on how they are talking cause a lot of what they are calling restraints are not restraints." -"I called DSS (Department of Social Services) on 1-29-24 and made the CPS (child protective services) report (on the 1-22-24 incident of staff #1 pulling client #1 by her shirt off of a chair and causing her to fall on the floor.) I thought that was all I had to do."	V 366		
V 367	27G .0604 Incident Reporting Requirements	V 367		

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V 367	Continued From page 24 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 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,	V 367		

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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 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)

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NEW BRIDGE	2442 SANDHURST COURT GASTONIA, NC 28054

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V 367	Continued From page 26 through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to report all Level II and III incidents in the 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 72 hours of becoming aware of the incident. Affecting 3 of 3 audited clients (clients #1, #2 and #3). The findings are: Review on 1-31-24 of the facility's "Report of Refusals" (incident/accident reports) for November 1, 2023 through January 31, 2024 revealed: -No documentation of an incident occuring on 1-20-24 of staff #1 pulling client #1 by her shirt off of a chair causing her to fall to the floor. -No documentation regarding client #1's behaviors of property destruction, verbal or physical aggression to staff or peers. -No documentation of physical restraints for client's #1, client #2 or client #3. Review on 1-31-24 of the North Carolina Incident Response Improvement System (IRIS) for November 1, 2024 through January 31, 2024 revealed: -No documentation of an incident occuring on 1-20-24 of staff #1 violently pulling client #1 by	V 367	All Level II and III incidents will be reported in IRIS & MCO within 72 hours of the provider being notified of the incident.	

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her shirt off of a chair causing her to fall to the floor.
-No documentation regarding client #1's behaviors of property destruction, verbal or physical aggression to staff or peers.
-No documentation of physical restraints for client's #1, client #2 or client #3.

Interview on 2-1-24 with client #1 revealed:
-"Yes, I been restrained (dates unknown), maybe twice. Only when I be bad."

Interview on 2-1-24 with client #2 revealed:
-Don't know if she has been restrained since she has been here but has seen the other girls get restrained.
-Cannot remember specific dates she witnessed the restraints.
-"[Staff #1] restrained [client #1]."
-Did not see the incident (staff #1 pulling client #1 by her shirt off of a chair causing her to fall to the floor). . "I just saw her (staff #1) restraining her (client #1)."

Interview on 2-1-24 with client #3 revealed:
-She was restrained one time.
-"Cause one time one staff (former staff (FS) #4) bought me something (a toy) and I wanted to keep the Spiderman thing on the top (of the toy) and she (FS #4) threw it away and I went in the trash can and tried to get it out and she keep taking it and she restrained me."
-"She (FS #4) grabbed my elbows and my elbows were back behind my back so I couldn't move."

Interview and observation on 2-1-24 at 3:04 pm with client #4 revealed:
-"[Staff #3] restrained me. Just once I was on the floor like that (demonstrates her position) and she put all her body weight on me. Then I spit on her

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and she put her arm around my neck (places her arm around her throat/neck area). It took about 5 hours."

Interview on 2-7-24 with staff #1 revealed:
-"Yes we (staff) do restraints."
-"[Client #1] has behaviors every day. She's just that type of kid. No matter what you do she's just [Client #1]."
-"She'll cuss you out, spit on you, hit you, throw things at you. [Client #1's] problem is No, if you say no to her that kid goes from a level 0 to 1,000 in 2 seconds. She is destructive (property damage), she raises hell all day."
-Documents behaviors on all the clients in the daily logs.

Interview on 2-1-24 with staff #3 revealed:
-"We are suppose to (use restraints) but I choose not to unless one of the kids become combative. We have not been properly exposed (trained) to restraints.
-"One of the kids was in a crisis and she was carrying on and picked up a chair and threw it at the other kids in the living room. I had to grab her by both of her wrist to make sure she didn't move. I made sure she was held until she calmed down it took her a long time to calm down she was real aggressive she actually spit in my face and I just had to hold her for like 5 minutes then I let her up."
-Did not complete an incident report.

Interview on 1-31-24 and 2-1-24 with the Executive Director (ED) revealed:
-The house manager is responsible for completing the incident reports.
-The house manager left "a couple of months" ago.
-"When they (staff) call me and tell me about

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V 367	Continued From page 29 these behaviors I always ask them if they completed a incident report. The house manager was the one that was suppose to make sure the incident reports were completed and submitted and I think that's where things fell through the cracks with the incident reporting." -"I think too, staff are not using the correct language, we don't do restraints. When they call me about a restraint I have to correct them. I ask them was it really a restraint or were you just impeding movement? If you are stopping someone from running by standing in front of them, that's not a restraint or if you hold someone's arms to keep them from hurting you another child then that's not a restraint. I tell them (staff) they have to be careful on how they are talking cause a lot of what they are calling restraints are not restraints." -"I called DSS (Department of Social Services) on 1-29-24 and made the CPS (child protective services) report (on the 1-22-24 incident of staff #1 pulling client #1 by her shirt off of a chair and causing her to fall on the floor.) I thought that was all I had to do."	V 367		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force	V 512		

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V 512	Continued From page 30 necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on record review and interview 1 of 1 audited staff (staff #1) abused 1 of 3 audited clients (client #1). The findings are: Review on 2-1-24 of client #1's record revealed: -Date of admission: 8-14-23. -Age: 11. -Diagnoses: Attention Deficit Hyperactivity Disorder, Predominately Hyperactive Type, Adjustment Disorder with Anxiety. Review on 2-1-24 of Staff #1's record revealed: -Date of hire: 3-24-23. -Job title: Direct Care Worker. Review on 2-1-24 and 2-9-24 of the facility's video footage revealed: -Due to the quality of the video the date and time stamp were unrecognizable however interview on 1-31-24 with the Executive Director (ED) reports the date of the video to be 1-22-24.. -Client #1 was standing around the dining room table with an object in her hands. Staff #3 was	V 512	Staff will continued to be trained throughout their employment at Bliss Haven. Trainings include but not limited to clients rights & population served. Staff have had refresher trainings on Clients Rights, Population Served & CPI.	

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V 512	Continued From page 31 sitting in a chair between the dining area and the kitchen island. Client #1 was hitting the table with an unknown object. Staff #1 moved from the opposite side of the table towards client #1 and attempted to grab the object from client #1's hand. Client #1 and Staff #1 began struggling over the object for approximately 10 seconds until staff #1 was able to pull the object from client #1's hands. Staff #1 walked away from client #1. Client #1 walked to the end of the table, picked up a chair and threw it against the wall. Client #1 walked to the kitchen island and began to talk in the direction of staff #1. There is no audio to the video however client #1 can be seen flailing her arms, hitting her legs and hitting a chair that was positioned beside the island. Staff #1 was on the opposite side of the kitchen island and she and client #1 were talking back and forth to each other. Client #1 sat down on the chair. Staff #1 came from the opposite side of the island and approached client #1. Staff #1 grabbed client #1 by the front of her shirt near the neck area and pulled her from the chair to the floor. Client #1 got up from the floor and grabbed a chair and attempted to hit staff #1 with the chair at which time staff #3 intervened by grabbing the chair. Client #1 ran around staff #3 and staff #1 followed her. Client #1 grabbed another chair with staff #1 also grabbing the chair at the same time. Client #1 and staff #1 struggled for the chair until the video ended. Interview on 1-31-24 and 2-1-24 and observation (2-1-24 at 4:15 pm) with client #1 revealed: -"We came back from a long ride. I was trying to slice tomatoes and out of the blue she (staff #1) snatched the tomato out my hand and said 'you ain't getting tomatoes' so I snatched it back out her hand. She picked me up by my arm and brung me in my room. She was pushing my head	V 512		

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down and her knee was in my back. After I turned over her knee was right here (pointed to her chest area). My chest was hurting for one thing."
-" First I kicked her (staff #1) cause she would not get off of me."
-After the altercation with staff #1 in client #1's bedroom, she went back to the kitchen area..."And that's when she grabbed me by my shirt and she took me up to the sky and threw me to the other side of the room and that's when I hit the wall."
-"She always threaten me. She say she gonna get me and stuff like that. She always grabs me and I don't like people grabbing on me. She (staff #1) is spiteful."

Interview on 1-31-24 with the Executive Director (ED) revealed:
-She became aware of the allegation on 1-27-24 when client #1 told her about the alleged interaction between staff #1 and client #1
-"I asked [staff #3] about the incident and spoke to [staff #1], [staff #1] denied the allegation. I looked at the camera footage from that date (1-22-24). I couldn't see what happened in the bedroom but what I did see (in the kitchen) alarmed me. I went ahead and suspended her (staff #1)."
-"I called DSS (Department of Social Services) and made a report to them on Monday (1-29-24).

Review on 2-15-24 of the Plan of Protection dated 2-15-24 and was written by the ED revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care? The director will suspend staff with harm, abuse or neglect allegation immediately until the investigation is complete. The director will enter

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V 512	Continued From page 33 the allegation into IRIS (Incident Response Improvement System) as well as complete the HPCR (Healthcare Personnel Registry) report. Should the allegation be substantiated, staff will be terminated immediately. Staff will be refreshed on trainings as well as the Abuse/Neglect Policy following an incident. Describe your plans to make sure the above happens. Staff will complete refresher trainings by March 18, 2024. Staff who do not attend the mandatory trainings will be removed from the schedule until trainings are complete. Staff who do not comply will receive disciplinary action, suspension and or termination." Client #1 is 11 years old with diagnoses including Attention Deficit Hyperactivity Disorder, Impulse Control, Anxiety, Adjustment Disorder, Conduct Disorder and Kleptomania. On 1-22-24 client #1 was having a behavior due to staff not allowing her to use a knife to cut a tomato. Client #1 began cursing at staff and became physically aggressive with staff #1 by hitting her about her face, (knocking her glasses off her face) and body. Staff #1 was unable to regulate client #1's behavior. Client #1 was sitting in a chair in the facility kitchen when staff #1 grabbed her by her shirt and pulled her off a chair causing her to fall to the floor. This deficiency constitutes a Type A1 rule violation for serious abuse and must be corrected within 23 days.	V 512		