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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on March 15, 2024. The complaint was unsubstantiated (intake #NC00214262). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents. The facility is licensed for 12 and currently has a census of 11. The survey sample consisted of audits of 3 current clients and 2 former clients.	V 000		
V 106	27G .0201 (A) (8-18) (B) GOVERNING BODY POLICIES 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (8) use of medications by clients in accordance with the rules in this Section; (9) reporting of any incident, unusual occurrence or medication error; (10) voluntary non-compensated work performed by a client; (11) client fee assessment and collection practices; (12) medical preparedness plan to be utilized in a medical emergency; (13) authorization for and follow up of lab tests; (14) transportation, including the accessibility of emergency information for a client; (15) services of volunteers, including supervision and requirements for maintaining client confidentiality; (16) areas in which staff, including	V 106		

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V 106	Continued From page 1 nonprofessional staff, receive training and continuing education; (17) safety precautions and requirements for facility areas including special client activity areas; and (18) client grievance policy, including procedures for review and disposition of client grievances. (b) Minutes of the governing body shall be permanently maintained. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to implement a policy for incident reporting. The findings are: Review on 3/7/24 of the facility's incident reporting policy revealed: "Level 1 Incidents: Any happening which is not consistent with the routine operation of a facility or service or routine care of a consumer and that is likely to lead to adverse effects upon a consumer and does not meet the definition of a Level II or Level III incident. This includes the following: Any medication error such as wrong dose, wrong medication, wrong time (over 1 hour from prescribed time), missed dose or medication refusal that does not threaten the consumer's health or safety (as determined by the physician notified of the error); (aggregate numbers will be reported to Local Management Entity (LME) for Level I medication errors quarterly)." Review on 3/7/24 of the January 2024 Medication Administration Record for client #2 revealed:	V 106		

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V 106	Continued From page 2 There were refusals for the following dates: -Ferrous Sulfate 325 milligrams (mg) (Iron Deficiency) on 1/18 -Vitamin C 500 mg (Immune Health) on 1/18 -Vitamin D 325 micrograms (mcg) (Vitamin D deficiency) on 1/18 -Metformin HCL 1000 mg (High Blood Sugar Levels) on 1/18 -Propranolol 20 mg (High Blood Pressure) on 1/18 -Propranolol 40 mg on 1/11 and 1/18 -Quetiapine Fumarate 200 mg (Depression) on 1/18 -Divalproex Sodium Delayed Release (DR) 500 mg (Bipolar Disorder) on 1/11 and 1/18 Review on 3/7/24 of facility records revealed: -There was no documentation of Level 1 incident reports completed for the above medication refusals for client #2. Interview on 3/7/24 with Registered Nurse #1 revealed: -Nurses were required to complete an incident report for medication refusals. -Some of the other nurses didn't work at the facility "very often." -"They possibly didn't know to complete an incident report if clients refused their medication." Interview on 3/7/24 with the Executive Director revealed: -The nurses were supposed to complete incident reports for medication refusals. -He was required to review the incident report after it was written by the nurses. Interview on 3/14/24 with the Vice President of Administration revealed:	V 106		

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V 106	Continued From page 3 -She didn't know client #2 was refusing his medication. -Nurses should be doing incident reports for medication refusals. -The Executive Director was responsible for ensuring the nurses completed Level 1 incident reports for medication refusals.	V 106		
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		

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V 112	Continued From page 4 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to develop and implement strategies to meet the needs of one of three audited current clients (#2). The findings are: Reviews on 3/6/24 and 3/7/24 of client #2's record revealed: -Admission date of 11/8/23. -Diagnoses of Disruptive Mood Dysregulation Disorder, Conduct Disorder and Mild Intellectual Disability. -He was 13 years old. -Person Centered Plan dated 1/22/24 had no strategies to address medication refusals. Review on 3/7/24 of the January 2024 Medication Administration Record for client #2 revealed: There were refusals for the following dates: -Ferrous Sulfate 325 milligrams (mg) (Iron Deficiency) on 1/18 -Vitamin C 500 mg (Immune Health) on 1/18 -Vitamin D 325 milligrams (mcg) (Vitamin D deficiency) on 1/18 -Quetiapine Fumarate 400 mg (Depression) on 1/10 -Metformin HCL 1000 mg (High Blood Sugar Levels) on 1/18 -Propranolol 20 mg (High Blood Pressure) on 1/10 and 1/18 -Propranolol 40 mg on 1/11 and 1/18 -Quetiapine Fumarate 200 mg on 1/18 -Divalproex Sodium Delayed Release (DR) 500 mg (Bipolar Disorder) on 1/11 and 1/18	V 112		

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V 112	Continued From page 5 Interview on 3/7/24 with client #2 revealed: -He had refused his medication a few days. -He didn't want to take his medication because it made him sleepy. Interview on 3/6/24 with Registered Nurse #2 revealed: -Client #2 had refused his medication 1-2 times with her. -Sometimes it's hard to wake him up in the morning. -Client #2 would refuse to get out of bed and then refuse to take his medication. Interview on 3/13/24 with the Care Manager revealed: -She did not know client #2 was refusing his medication in January 2024. -That did not come to her attention during any of the Child and Family Team (CFT) meetings. -She was not getting any incident reports for client #2's medication refusals. -She confirmed client #2 had no strategies to address medication refusals. Interview on 3/14/24 with the Vice President of Administration revealed: -She didn't know client #2 was refusing his medication. -The Care Manager was responsible for adding strategies to a client's plan. -She confirmed client #2 had no strategies to address medication refusals.	V 112		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS	V 123		

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V 123	Continued From page 6 (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. . This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure medication refusals were reported immediately to a physician or pharmacist for one of three audited current clients (#2). The findings are: Review on 3/7/24 of the January 2024 Medication Administration Record for client #2 revealed: There were refusals for the following dates: -Ferrous Sulfate 325 milligrams (mg) (Iron Deficiency) on 1/18 -Vitamin C 500 mg (Immune Health) on 1/18 -Vitamin D 325 micrograms (mcg) (Vitamin D deficiency) on 1/18 -Quetiapine Fumarate 400 mg (Depression) on 1/10 -Metformin HCL 1000 mg (High Blood Sugar Levels) on 1/18 -Propranolol 20 mg (High Blood Pressure) on 1/18 -Propranolol 40 mg on 1/11 and 1/18 -Quetiapine Fumarate 200 mg on 1/18 -Divalproex Sodium Delayed Release (DR) 500 mg (Bipolar Disorder) on 1/11 and 1/18	V 123		

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V 123	Continued From page 7 Review of facility records on 3/7/24 revealed: -There was no documentation facility staff notified the physician or pharmacist of medication refusals for client #2. Interview on 3/7/24 with the Executive Director revealed: -The nurses were supposed to call the physician or pharmacist for medication refusals. -He wasn't sure why the nurses failed to report the January 2024 medication refusals to the physician or pharmacist for client #2. Interview on 3/14/24 with the Vice President of Administration revealed: -She didn't know client #2 was refusing his medication. -The nurses should be reporting medication refusals to the physician or pharmacist. -The Executive Director was responsible for ensuring the nurses contact the physician or pharmacist about medication refusals for clients.	V 123		
V 315	27G .1902 Psych. Res. Tx. Facility - Staff 10A NCAC 27G .1902 STAFF (a) Each facility shall be under the direction a physician board-eligible or certified in child psychiatry or a general psychiatrist with experience in the treatment of children and adolescents with mental illness. (b) At all times, at least two direct care staff members shall be present with every six children or adolescents in each residential unit. (c) If the PRTF is hospital based, staff shall be specifically assigned to this facility, with responsibilities separate from those performed on an acute medical unit or other residential units.	V 315		

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V 315	Continued From page 8 (d) A psychiatrist shall provide weekly consultation to review medications with each child or adolescent admitted to the facility. (e) The PRTF shall provide 24 hour on-site coverage by a registered nurse. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to provide 24-hour on-site coverage by a Registered Nurse (RN). The findings are: Reviews on 3/6/24, 3/7/24 and 3/8/24 of the facility's personnel records for Nurses revealed: RN #1: -Date of hire was 3/26/15. RN #2: -Date of hire was 5/14/23. RN #3: -Date of hire was 3/3/23. RN #4: -Date of hire was 4/2020 (no specific day). RN #5: -Date of hire was 9/25/22. Review on 3/13/24 of schedules for nursing staff revealed: March 2024: -No RN scheduled 7pm to 7am (2nd shift) on 3/1,	V 315		

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V 315	Continued From page 9 3/2, 3/3, 3/6, 3/7, 3/11, 3/12, 3/16, 3/17, 3/18, 3/20, 3/21, 3/24, 3/25, 3/26, 3/29, 3/30 and 3/31. -Total prior and during survey period was 7 days no 24-hour RN coverage February 2024: -No RN scheduled 2nd shift on 2/3, 2/4, 2/7, 2/8, 2/12, 2/13, 2/14, 2/17, 2/18, 2/21, 2/22, 2/25, 2/27 and 2/28 -Total for month was 14 days no 24-hour RN coverage January 2024: -No RN scheduled on 1/1 for both shifts 7am to 7pm (1st) and 2nd -2nd shift on 1/2, 1/3, 1/6, 1/7, 1/11, 1/14, 1/15, 1/17, 1/20, 1/21, 1/25,1/29 and 1/31. -Total for month was 13 days no 24-hour RN coverage Interview on 3/7/24 with client #1 revealed: -Sometimes they didn't have a registered nurse at the facility. -"It normally happens in the evenings." -"It happens about 2 days a week." -"They were without a nurse last night (3/6/24)." Interview on 3/7/24 with client #3 revealed: -Sometimes there was no registered nurse in the building in the evenings (7pm to 7am). -He thought that happened about once a week. Interview on 3/7/24 with client #4 revealed: -Sometimes there was no registered nurse in the building about 1-2 days a week. Interview on 3/7/24 with client #5 revealed: -There was no registered nurse in the building sometimes. -He was not sure how often that occurred.	V 315		

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V 315	Continued From page 10 Interview on 3/7/24 with client #6 revealed: -Sometimes there was no registered nurse in the building in the evenings or all day. -He had not seen a registered nurse in the building all day twice. -There was no registered nurse last night (3/6/24) for 2nd shift (7pm to 7am). -About 2-3 days a week there was no registered nurse during 2nd shift (7pm to 7am). Interview on 3/7/24 with staff #3 revealed: -He worked 1st and 2nd shifts at the facility. -There was no registered nurse for 2nd shift (7pm to 7am) on Wednesday night (3/6/24). -There was always a registered nurse whenever he worked 1st shift (7am to 7pm). -Whenever he worked 2nd shift (7pm to 7am) there were 2 times there was no registered nurse at the facility. Interview on 3/8/24 with staff #4 revealed: -Some evenings (7pm to 7am) there was no registered nurse working at the facility. -There may be no registered nurse at the facility about 3 days a week in the evenings (7pm to 7am). Interview on 3/6/24 with RN #1 revealed: -She worked 3 days a week during the day shift (7am to 7pm). -"It continues to be an issue not having RN coverage for 2nd shift." -About 2 days a week there was no registered nurse for 2nd shift (7pm to 7am). -There was no registered nurse scheduled to work tonight (3/6/24). Interview on 3/6/24 with RN #2 revealed: -She worked 3 days a week during the day shift	V 315		

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(7am to 7pm).
-During 2nd shift (7pm to 7am) there was not always a registered nurse available to work.
-There was no registered nurse at the facility about 1-2 days a week for 2nd shift (7pm to 7am).

Interview on 3/13/24 with RN #4 revealed:
-She normally worked 2nd shift (7pm to 7am) at the facility.
-She had not worked at the facility since last November 2023 because she was on sick leave.
-She had an issue with there not being a registered nurse in the building.

Interview on 3/11/24 with RN #5 revealed:
-She worked 2-3 days during 2nd shift (7pm to 7am) at the facility.
-The registered nurses working 1st shift (7am to 7pm) would "sometimes leave early."
-"That happens about 50% of the time."
-She normally came in around 6:15 pm.
-Sometimes the registered nurses were leaving as she was walking in and sometimes they were not there at all.
-RN #1 and RN #2 were the two nurses leaving early.
-Sometimes there was no registered nurse there at 7:00 am to relieve her.
-"I would leave the facility anyway even though there was no nurse."
-She was not sure if another registered nurse was showing up or just late for work.

Interviews on 3/6/24, 3/8/24 and 3/12/24 with Executive Director revealed:
-They were going through a staffing agency to get registered nurses as needed.
-As far as he knew registered nurses were in the building 24 hours a day.

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-He didn't know a registered nurse didn't show for work on Wednesday night (3/6/24).
-They only use the staffing agency as needed.
-"If one of the nurses doesn't show for their shift and they don't have prior notice they can't use the staffing agency."
-"The nursing schedule had already been completed and we expect the scheduled nurse to report to work."
-He was not aware of any of the registered nurses leaving prior to their shift ending.
-It has never came to his attention that RN #1 and RN #2 were leaving before their shift ends at 7:00 pm.

Interview on 3/14/24 with the Vice President of Operations Administration (VPA) revealed:
-"I didn't know there was still an issue with the facility having RN coverage 24 hours daily."
-That issue had not come to her attention since the December 2023 survey.
-They were using a staffing agency to get nurses.
-They had seven registered nurse working for both buildings.
-She didn't know the registered nurses were leaving the facility early.
-She was not aware of there being days when there was no registered nurse working during 2nd shift.
-She confirmed the facility did not have 24-hour on-site coverage by a registered nurse.

Review on 3/15/24 of a Plan of Protection written by the VPA dated 3/15/24 revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care? The facility will schedule RN's daily on each shift. Describe your plans to make sure the above happens. The [Director of Operations] will review the nursing schedule monthly. We will increase

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V 315	Continued From page 13 the budget for our recruitment ads to reach more candidates. We will contact our staffing company (name of company) about the possibility of assigning an on-call RN daily in the event a scheduled RN is unable to report to work. We will also schedule our own RN's as on-call." The facility served clients whose diagnoses included: Disruptive Mood Dysregulation Disorder, Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, Conduct Disorder, Oppositional Defiant Disorder, Major Depressive Disorder, Mild Intellectual Disability, Borderline Intellectual Functioning and Cannabis Abuse. The clients ages ranged between 11 to 16 years old. There was no registered nurse scheduled for 2nd shift (7pm to 7am) 34 times between January 1, 2024 and March 15, 2024. There was no registered nurse in the building during 2nd shift (7pm to 7am) between 1-3 days a week. This deficiency constitutes a Continuing Type A1 rule violation originally cited for serious neglect for failure to correct within 23 days.	V 315		
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 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 interviews, the facility was not maintained in a safe, clean, attractive, orderly manner and kept free from offensive odor. The findings are:	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL047-131	A. BUILDING: _____ B. WING _____	C 03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE GARDENS TREATMENT CENTER	1958 TURNPIKE ROAD RAEFORD, NC 28376

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V 736	Continued From page 14 Observation on 3/6/24 at approximately 2:55 PM revealed: -Client #9's bedroom-Paint peeling on walls. Approximately 8 pieces of sticker debris on plexiglass window. A piece of burgundy fabric and candy paper wrapper in between window and plexiglass. -Client #6's bedroom-Approximately 12 dime sized dents in door to bedroom. Paint peeling on walls. Green crayon drawings on the walls. -Client #4's bedroom-Approximately 5 rips in mattress about 1 inch long. Approximately 10 pieces of sticker debris on plexiglass window. Two plastic pieces from blinds and a sheet of notebook were in between window and plexiglass. -Client #1's bedroom- Approximately 6 orange and black stains on bedroom door. Approximately 10 dime sized dents in bedroom door. Paint peeling on column. Pink gum and black scuff marks on plexiglass. Door jamb was rusted. -Empty bedroom-Caulking putty on walls approximately 2 feet long and 2 feet wide. -Client #5's bedroom-Approximately 50 pencil markings on the walls. Approximately 8 sheets of notebook paper, comforter, 3 pairs of socks, underwear, blanket on the floor. Four socks, 2 empty potato chip bags and approximately 12 sheets of paper were underneath his mattress. Approximately 12 marker drawings were on his bedroom door. -Bathroom near client #5's bedroom-Mirror was discolored. Four dime sized dents in the door. -Bathroom near client #6's bedroom-Mirror was discolored. Musty odor. The shower rod was rusted. Yellowish stains towards back of toilet bowl. -Bathroom near client #11's bedroom -Mirror was discolored. Strong urine smell. Yellowish stains towards back of toilet bowl. Approximately 20	V 736		

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V 736	Continued From page 15	V 736		

pieces of human hair on sink counter. The wooden border near shower towards floor was pinkish colored.
-Client #10's bedroom- Approximately 6 pieces of sticker debris on plexiglass window. Writing on border around the window. Approximately 10 crayon markings and peeling paint on the walls. Door jamb had peeling paint and was rusted.
-Jacob-Client #3's bedroom- Door jamb was rusted. Plexiglass over window had a crack approximately 3 inches wide and 2 inches long and a dime sized hole.
-Client #7's bedroom-Rusted door jamb.
-Client #3's bedroom-Approximately 100 pencil and chalk drawings on the walls. Door jamb peeled and paint and rusted.
-Client #11's bedroom-Approximately 16 stacks of cut sheet of paper with a piece of fabric wrapped around them, 3 stuffed animals, comb, brush, 3 socks, head phones, a hand held game and approximately 100 pieces of cotton fabric rolled up in a ball were piled on top of the bed. Three stuffed animals, 3 socks, approximately 100 pieces of paper (worksheets/notebook), sweatshirt and a bath cloth were on the floor. Door jambs were rusted.

Interview on 3/6/24 with the Executive Director revealed:
- He was aware of the maintenance issues with the facility.
-Some of the issues were addressed after the December 2023 survey.
-They were "constantly" talking to the clients about keeping their bedrooms clean.
-He confirmed the facility was not maintained in a safe, clean, attractive, orderly manner and kept free from offensive odor.

Interview on 3/14/24 with the Vice President of

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	MHL047-131	A. BUILDING: _____ B. WING _____	C 03/15/2024

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HOPE GARDENS TREATMENT CENTER	1958 TURNPIKE ROAD RAEFORD, NC 28376

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V 736	Continued From page 16 Administration revealed: -We had a maintenance person for all 4 facilities. -"As soon as the maintenance person fix the facility, clients mess it up again." -The building was painted and other issues were addressed after the December 2023 survey. -She confirmed the facility was not maintained in a safe, clean, attractive, orderly manner and kept free from offensive odor. This deficiency has been cited 4 times since the original cite on 7/20/22 and must be corrected within 30 days	V 736		