	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		IDENTIFICATION NOMBER.	A. BUILDING:		COMPLETED	
		MHL036-343			04	R 4/10/2024
NAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
	PHIRE HOUSE	107 WE	ST LOUISIANA AVE	NUE		
		BESSEM	MER CITY, NC 2801	6		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMENTS	5	V 000			
		ow up survey was completed aplaint was substaniated ( iencies were cited.				
		ed for the following service 27G .1700 Residential ure of Children or				
	This facility is licensed for four and currently has a census of two. The survey sample consisted of audits of two current clients.					
V 293	27G .1701 Residenti	al Tx. Child/Adol - Scope	V 293			
	children or adolescer free-standing resider intensive, active ther interventions within a shall not be the prima who is not a client of (b) Staff secure mea awake during client s shall be continuous a this Section. (c) The population s adolescents who hav mental illness, emoti substance-related dis co-occurring disorded disabilities. These cl not meet criteria for i (d) The children or a require the following:	attment staff secure facility for ints is one that is a intial facility that provides apeutic treatment and a system of care approach. It ary residence of an individual the facility. ans staff are required to be sleep hours and supervision as set forth in Rule .1704 of erved shall be children or ve a primary diagnosis of onal disturbance or sorders; and may also have rs including developmental hildren or adolescents shall npatient psychiatric services. adolescents served shall				
	( )	sidential setting in order to				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			E SURVEY PLETED
			A. BUILDING: B. WING			
		MHL036-343			04	R // <b>10/2024</b>
IAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
BLUE SAF	PHIRE HOUSE					
			AER CITY, NC 2801			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 293	Continued From page	e 1	V 293			
	<ul> <li>(e) Services shall be</li> <li>(1) include indistructure of daily livin</li> <li>(2) minimize the related to functional of (3) ensure safe control behaviors inclusion of adaptive communication, social (5) support the gaining the skills nee intensive treatment set (f) The residential tree shall coordinate with the set (f) and the set (f) and the state of the state of the skills nee with the coordinate with the coor</li></ul>	vidualized supervision and g; e occurrence of behaviors deficits; ety and deescalate out of luding frequent crisis without physical restraint; hild or adolescent in the e functioning in self-control, al and recreational skills; and child or adolescent in ded to step-down to a less etting. eatment staff secure facility				
	facility failed to coord and agencies within t	and record reviews the inate with other individuals he child or adolescent's ing one of two clients (Client				
	Health Clinicans at C	f Letter from the Mental lient #1's school revealed: ental Health Clinician at				

STATEMENT	of Health Service Regu OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			
AND PLAN C	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMPLETED	
		MHL036-343			04	R / <b>10/2024</b>
IAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	PHIRE HOUSE	107 WES	ST LOUISIANA AVE	NUE		
BLUE SAF	PHIKE HOUSE	BESSEN	IER CITY, NC 2801	6		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
V 293	Continued From page	e 2	V 293			
	rather to provide chee needed for additional skills, communication management skills ar students in their wellr -Listed multiple of Clinician had checkee -Client #1 has be based therapy provid "However, in the past been various gaps in not being able to fill th at the beginning of th (2023), as well as this January 2024 to the p Interview on 3-7-24 a revealed: -She gets therap -She gets her the	nd overall supporting hess goals." days that Mental Health d in with Client #1. een signed up for school ed by a local agency, t school year there have service due to the agency heir vacancy, such as briefly e school year in Augurs s entire semester, from bresent." and 3-21-24 with Client #1 by at school. erapy from school. alth Clinician from the school d to."				
		ofessional revealed:				
	Interview on 3-21-24 health Clinician revea -Her role at the s the students. -Client #1 was se	with the school Mental				
	since January 2024. -The contracted	company had not had a				

STATE FORM

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
	MHL036-343		B. WING		04	R I/10/2024	
NAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
BLUE SAF	PHIRE HOUSE		ST LOUISIANA AVE WER CITY, NC 280 <sup>7</sup>				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	D THE APPROPRIATE	COMPLETE DATE	
V 293	Continued From page	e 3	V 293				
	therapist since January. -She had informed Client #1's facility of the issue.						
	Interview on 3-21-24 with agency providing therapy revealed: -They did not have a therapist at the time,						
	and they had let the school and the facility know this. -They did have Intensive In Home therapy to						
	bridge the gap, and a	a day treatment program. specifically looking for school					
V 296	27G .1704 Residenti Staffing	al Tx. Child/Adol - Min.	V 296				
	telephone or page.	4 MINIMUM STAFFING ssional shall be available by A direct care staff shall be lity within 30 minutes at all					
	(b) The minimum nu required when childre present and awake is						
	one, two, three or fou	are staff shall be present for ir children or adolescents; care staff shall be present eight children or					
	adolescents; and (3) four direct of nine, ten, eleven or tr adolescents.	care staff shall be present for welve children or					
	(c) The minimum nu	mber of direct care staff scent sleep hours is as					
		are staff shall be present					

Division of Health Service Regulation STATE FORM

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STATEMENT OF DEFICIENCIES     (X1) PROVIDER/SUPPLIER/CLIA       AND PLAN OF CORRECTION     IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING: B. WING			
		MHL036-343			04	R I/ <b>10/2024</b>
IAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE		
BLUE SAP	PHIRE HOUSE		ST LOUISIANA AVE MER CITY, NC 2801			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 296	Continued From pag		V 296			
	<ul> <li>and both shall be aw children or adolescer</li> <li>(3) three direct of which two shall be asleep for nine, ten, a adolescents.</li> <li>(d) In addition to the care staff set forth in Rule, more direct car the facility based on individual needs as splan.</li> <li>(e) Each facility shall supervision of childred are away from the facility</li> </ul>	care staff shall be present ake for five through eight hts; and t care staff shall be present awake and the third may be eleven or twelve children or minimum number of direct Paragraphs (a)-(c) of this re staff shall be required in the child or adolescent's specified in the treatment I be responsible for ensuring en or adolescents when they cility in accordance with the individual strengths and				
	interviews, the facility	n, record reviews, and y failed to insure two direct ent for one, two, three or four				
	revealed:	24 at approximately 1:30pm wo clients (Client #1 and				
	Review on 3-11-24 o	f Client #1's record revealed:				

STATE FORM

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
		MHL036-343	B. WING		04	R 1/10/2024
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	PHIRE HOUSE	107 WES	ST LOUISIANA AVE	NUE		
LUE SAF	PHIKE HOUSE	BESSEN	MER CITY, NC 2801	16		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O		(X5)
PREFIX TAG	``	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE
V 296	Continued From page	e 5	V 296			
	-Admitted 9-20-2	22.				
	-14 years old.					
		ide: Generalized Anxiety				
	Disorder, DI Georges					
	-Assessment dated 8-22-22 revealed; "being					
	recommended for placement into a Level 3					
	Residential treatment facility. She has					
	demonstrated the ability to self-soothe when					
	given appropriate staff intervention and					
	assistance. Staffing a this level of care will					
	continue to provide [Client #1] the support that					
	she requires in a safe and contained					
	environment."					
	-Person Centered Plan dated 11-27-23					
	revealed; is verbally and physically aggressive					
	when angry and has a difficult time gauging					
	riskcurrently staying in a level III group home while she awaits a higher level of caredifficulty					
		ons and managing her anger.				
	Review on 3-11-24 of -Admitted 1-18-2	f Client #2's record revealed: 24.				
		ide: Adjustment disorder				
	0	nd depressed mood, Post				
	-	order, Attention Deficit				
	Disorder, Oppositiona	al Defiant Disorder,				
	Intermittent Explosive	e Disorder,, Disinhibited				
		Disorder, Chromosome				
	Abnormality, unspeci					
		ted 12-15-23 revealed: went				
	•	ntial Treatment Facility				
	(PRTF) due to failure					
		d alterationsstruggles with				
		commend PRTFafter that dtransition to back to				
	family.					
	iaiiiiy.					
	Interview on 3-7-24 w	vith Client #1 revealed:				
	-	lly 2-3- staff at the facility.				

If continuation sheet 6 of 7

				(X2) MULTIPLE CONSTRUCTION		
			A. BUILDING: B. WING		COMPLETED	
		MHL036-343			04/10/2024	
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE		
LUE SAF	PHIRE HOUSE		T LOUISIANA AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 296	Continued From page	e 6	V 296			
	-Today, the seco so they left.	ond staff had an appointment,				
		vith Client #2 revealed: vas just one staff, but she				
	Interview on 3-7-24 with Staff #1 revealed: -There are normally two staff per shift, but one staff had a funeral to go to, so she had left for a while. Interview on 3-11-24 with the Clinical Director/Qualified Professional revealed: -They had two staff, but that day one staff had to go to a funeral, but came right back.					
		,,				