| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | | B) DATE SURVEY COMPLETED | |
|---|---|--|---------------------|---|--------|-----------------------------|--|
| | | MHL026-988 | B. WING | | 04/0 | 3/2024 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, S | TATE, ZIP CODE | | | |
| VIRINGIA | A'S GROUP HOME | | HWY 210 S | 40 | | | |
| | | | LLE, NC 283 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETE DATE | |
| V 000 | INITIAL COMMENT | rs | V 000 | | | | |
| | on April 3, 2024. Or unsubstantiated and substantiated (intak #NC00214932). De This facility is licens category/categories Residential Treatmo or Adolescents. The facility is licens census of 2. The s | plaint survey was completed ne complaint was done complaint was the #NC00215049 and ficiencies were cited. Seed for the following service of the secure for Children the secure for Children and Currently has a curvey sample consisted of clients and 3 former clients. | | | | | |
| V 1114 | 10A NCAC 27G .02 AND SUPPLIES (a) A written fire pla area-wide disaster shall be approved be authority. (b) The plan shall be and evacuation proposted in the facility (c) Fire and disaster shall be held at least repeated for each sunder conditions the | ncy Plans and Supplies 207 EMERGENCY PLANS In for each facility and plan shall be developed and by the appropriate local The made available to all staff cedures and routes shall be an an article of the conducted at simulate fire emergencies. It have basic first aid supplies | V 114 | | | | |
| | This Rule is not me Based on record re | et as evidenced by: view and interviews the facility | | | | | |

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

(X6) DATE TITLE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | E CONSTRUCTION | L COMBI | |
|---|---|--|---------------------------|--|---------|--------------------------|
| | | | | | | |
| | | MHL026-988 | B. WING | | 04/0 | 3/2024 |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| VIRINGIA | A'S GROUP HOME | | HWY 210 S LLE, NC 283 | 318 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | JLD BE | (X5) COMPLETE DATE |
| V 114 | Continued From pa | nge 1 | V 114 | | | |
| | | and disaster drills were held and repeated on each shift. The | | | | |
| | 2023 - February 20 Fire: - No fire drills were quarter August 202 11pm-8am or 8pm- - No fire drills were quarter November 2 2pm-8pm, 8pm-11p shifts No documented fi February 2024 - Ma | documented during the 3 - October 2023 on the 8am weekday shifts. documented during the 2023 - January 2024 on the 9m or the 8pm-8am weekday fire drills provided for review for earch 2024. | | | | |
| | quarter August 202 8am-8pm Weekend - No documented d | were documented during the 3 - October 2023 on the d shift. lisaster drills provided for 2024. | | | | |
| | | 4 client #2 stated she had not e or disaster drill since her 24. | | | | |
| | 2023 She worked 40 ho 8pm shift Drills were comple participated. | e Manager stated; at the facility since August ours a week, normally the 2pm- eted monthly and all clients | | | | |
| | Interview on 3/26/2 stated: | 4 and 4/3/24 the Director | | | | |

Division of Health Service Regulation

STATE FORM 6899 XR0J11 If continuation sheet 2 of 7

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---------------------------------|--|---|--|--|-------------------------------|--------------------------|
| | | MHL026-988 | B. WING | | 04/0 | 3/2024 |
| VIRINGIA'S GROUP HOME 7105 NC H | | | DRESS, CITY, S HWY 210 S LLE, NC 283 | STATE, ZIP CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | ILD BE | (X5) COMPLETE DATE |
| V 114 | - The facility's first of the facility's week 3pm- 11pm are con 8pm- 8am, 11pm- 8 - Shifts on the week 8pm- 8am The staff that come comes in to prep the after 3 two staff are - The second shifts have different scheme. | client was admitted 7/24/23. cday shifts were: 2pm- 8pm, sidered second shifts and dam are consider third shifts. dends were 8am- 8pm and des in at 2pm during the week de house, when clients arrive at the facility. are considered one shift. Staff dules. staff's schedules and she | V 114 | | | |
| V 297 | P 10A NCAC 27G .17 LICENSED PROFE (a) Face to face cli provided in each face week by a licensed this Rule, licensed this Rule, licensed by the an human service procarolina. For subsishall include a license shall include (1) clinical suprofessional specific section; (2) individual services; or (3) involvements | nical consultation shall be cility at least four hours a professional. For purposes of professional means an a license or provisional are governing board regulating ofession in the State of North tance-related disorders this sed Clinical Addiction fied Clinical Supervisor. | V 297 | | | |

Division of Health Service Regulation

STATE FORM 6899 XR0J11 If continuation sheet 3 of 7

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|---|---|--|-------------------------|---|-------------------|--------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED | |
| | | MHL026-988 | B. WING | | 04/0 | 3/2024 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | — DRESS, CITY, S | STATE, ZIP CODE | | | |
| VIRINGIA | A'S GROUP HOME | 7105 NC H | HWY 210 S LE, NC 283 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5) COMPLETE DATE | |
| V 297 | Continued From pa | ge 3 | V 297 | | | | |
| | facility failed to ensiconsultation was properties four hours a week to (LP). The findings at Review on 3/26/24 - 12 year old female - Diagnoses included Dysregulation Disorder, Attention Adjustment Disorder - No documentation LP hours completed | views and interviews the ure face to face clinical rovided in the facility at least by a Licensed Professional are: of client #1's record revealed: a admitted 2/1/24. and Disruptive Mood rder, Oppositional Defiant Deficit Hyperactivity Disorder, and Unspecified Trauma. In of four weekly face to face d. | | | | | |
| | 15 year old female Diagnoses include Anxiety Disorder-Undisruptive, Impulse and Unspecified Att Disorder. | of client #2's record revealed: e admitted 2/21/24. ed Major Depressive Disorder, nspecified, Unspecified Control and Conduct Disorder tention Deficit Hyperactivity n of 4 weekly face to face LP | | | | | |
| | record revealed: - 17 year old female - Diagnoses include Unspecified; Adjust Anxiety and Depres | ed Bipolar Disorder, tment Disorder with Mixed | | | | | |

Division of Health Service Regulation STATE FORM

Review on 3/27/24 of FC #6's record revealed:

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | (X3) DATE COMP | |
|--------------------------|---|--|---------------------|--|-------------------|--------------------------|
| | | MHL026-988 | B. WING | . WING | | 3/2024 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| VIRINGIA | A'S GROUP HOME | 7105 NC H | IWY 210 S | | | |
| VIIXIIVOIA | | | LE, NC 283 | 318 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| V 297 | Continued From pa | ge 4 | V 297 | | | |
| | Hyperactivity Disord Disorder No documentation hours completed. Interviews on 4/3/24 | ed Disruptive Mood der, Attention Deficit der and Post Traumatic Stress a of 4 weekly face to face LP 4 client #1 revealed: virtual therapy sessions rapist. | | | | |
| | Interview on 3/27/24 client #2 stated: - She talked with the therapist once a week during virtual sessions She had never seen the therapist at the facility - Therapy was going well for her. | | | | | |
| | Interview on 4/3/24 the LP stated: - She had weekly virtual therapy sessions with the clients She had onsite therapy sessions at the facility every other month where she would be there for most of the day. | | | | | |
| | - She understood th | the Director stated: ne requirement of face to face to be provided in the facility at reek by a LP. | | | | |
| V 300 | 27G .1708 Residen dischg | tial Tx. Child/Adol - Trans or | V 300 | | | |
| | DISCHARGE (a) The purpose of | 08 TRANSFER OR this Rule is to address the e of a child or adolescent | | | | |

Division of Health Service Regulation

STATE FORM 6899 XR0J11 If continuation sheet 5 of 7

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPI | (X2) MULTIPLE CONSTRUCTION (X3) I | | (3) DATE SURVEY | |
|--|--|---------------------|---|---------|--------------------------|--|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING | A. BUILDING: | | COMPLETED | |
| | MHL026-988 | B. WING | | 04/0 | 3/2024 | |
| NAME OF PROVIDER OR SUPP | | EET ADDRESS, CITY, | STATE ZIP CODE | 1 0 110 | <u> </u> | |
| | 710 | 5 NC HWY 210 S | 517(12, 211 GGBL | | | |
| VIRINGIA'S GROUP HON | = | RYVILLE, NC 28 | 318 | | | |
| PREFIX (EACH DEFIC | Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDENCY) | D BE | (X5) COMPLETE DATE | |
| or transferred emergency, winotification of the legally responsions. Rule, treatment existing child apersons as set (c). The facility family teams of the parent(s) of county program representative treatment of the local Department Education Age make service promotify the treatment of the local Department of the local Department Education Age make service promotify the treatment of the local Department of the local Department Education Age make service promotify the treatment of the local Department Education Age make service promotify the treatment of the local Department Education Age make service promotify the treatment of the local Department of the local Department Education Age make service promotified or advantage of the local Department of the local Departm | idolescent shall not be dischar from a facility, except in case of thout the advance written he treatment team, including the lible person. For purposes of the team means the same as the not family team or other involved forth in Paragraph (c) of this Fahall meet with existing child are other involved persons include regal guardian, area authority in representative(s) and other is involved in the care and echild or adolescent, including ent of Social Services, Local not and criminal justice agencial planning decisions prior to the charge of the child or adolescent. In an emergency, the facility shall ment team including the legally reson of the transfer or discharge of the child or adolescent as soon as the emergical energency, notification mand a service planning meeting as apply (c) of this Rule shall be hencess days of an emergency | ility LEA) emer | | | | |

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--|---|---|-----------------------------|--|-------------------|--------------------------|
| | | MHL026-988 | B. WING | | 04/0 | 3/2024 |
| NAME OF I | | | | OTATE ZID CODE | 1 04/0 | 3/2024 |
| NAME OF I | PROVIDER OR SUPPLIER | | DRESS, CITY, S HWY 210 S | STATE, ZIP CODE | | |
| VIRINGIA | A'S GROUP HOME | | LLE, NC 283 | 318 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE |
| V 300 | Continued From pa | nge 6 | V 300 | | | |
| | 17 year old female Diagnoses include Unspecified; Adjust Anxiety and Depres No documentation Child and Family Te | ed Bipolar Disorder, tment Disorder with Mixed | | | | |
| | Review on 3/27/24 of FC #6's record revealed: - 16 year old female admitted 2/3/24 Diagnoses included Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder and Post Traumatic Stress Disorder No documentation the LEA was included in the Child and Family Team (CFT) meeting or notified of FC #5's discharge within five business days of discharge. | | | | | |
| | of the local school s - FC #5 had not atta - The school had not that client's #5 and | n 3/27/24 three representatives stated: ended school since 2/26/24. ot received notice of any kind 6's would not be returning to had been discharged from the | | | | |
| | Director stated: - The 9th grade sch about FC #5's abse school counselor th to the hospital an w was unsure of the o | apart of any CFT meetings | | | | |

Division of Health Service Regulation