STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual, complaint, and follow up survey was completed on June 18, 2024. Ten complaints were substantiated (intakes #NC00201459, #NC00201594, #NC00202265, #NC00202501,#NC00206416, #NC00204971,#NC00207231, #NC00209562, #NC00214603, #NC00213918) and eleven complaints were unsubstantiated (intakes #NC00201754, #NC00202230, #NC00202270, #NC00207292, #NC00208082, #NC00208742, #NC00209173, #NC00212069, #NC00216487, #NC00212990, #NC00217011). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1800 Intensive Residential Treatment for Children and Adolescents. This facility is licensed for 12 and currently has a census of 8. The survey sample consisted of audits of 7 current clients and 11 former clients.	V 000		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV;	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 113	Continued From page 1 (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to maintain a complete client record for 5 of 11 former clients (FC) (#9, #15 #16, #18, and #19). The findings are: Finding #1	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 113	Continued From page 2 Review on 05/14/24 of FC #9's record revealed: -No client record was able to be located by facility staff. -Admission date was identified as 04/17/23 on the January 2024 MAR. Finding #2 Review on 05/15/24 of FC #15's record revealed: -18 year old male. -Admitted on 04/2/23. -Discharged on 04/26/23. -Diagnoses of Conduct Disorder (CD), Attention Deficit Hyperactivity Disorder (ADHD), Major Depressive Disorder (MDD), and Oppositional Defiant Disorder (ODD). -No client record to include admission assessment, treatment plan, documentation of emergency information and permission to seek emergency care or documentation of services provided. Finding #3 Review on 05/16/24 of FC #16's record revealed: -No client record was able to be located by facility staff. -A discharge summary was provided with an admission date of 04/25/23, discharge date of 06/08/23, and diagnoses of CD - childhood onset, Depression, and ADHD. Finding #4 Review on 05/17/24 of FC #18's record revealed: -No client record was able to be located by facility staff. -A discharge summary was provided with an admission date of 02/22/23, discharge date of 09/08/23, and diagnoses of CD, ADHD, and Generalized Anxiety Disorder (GAD). Finding #5	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 113	Continued From page 3 Review on 05/15/24 of FC #19's record revealed: -No client record was able to be located by facility staff. During interview on 05/15/24 and 05/21/24 the Executive Director revealed: -She had only been at the facility for approximately a month. -She was not able to locate a full record or any record for client's #9, #15, #16, #18 and #19.	V 113		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes. (b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate the facility's response to fire emergencies. (d) Each facility shall have a first aid kit accessible for use.	V 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 114	Continued From page 4 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to have fire and disaster drills held at least quarterly and repeated on each shift. The findings are: During interview on 05/14/24 the Residential Director revealed: -The facility had 3 shifts. -The shifts were 1st-7:00am-3:00pm, 2nd-3:00pm-11:00pm, and 3rd-11:00pm-7:00am. Review on 05/14/24 of the facility records from April 2023 to May 2024 revealed: -1st Quarter January 2024-March 2024: No 3rd shift for disaster drills. -2nd Quarter April 2024-June 2023: No 2nd shift fire drills and no 3rd shift disaster drills. -3rd Quarter July 2023-September 2023: No 3rd shift fire drills and no 2nd or 3rd shift disaster drills. -4th Quarter October 2023-December 2023: No 1st or 3rd shift disaster drills. During interview on 05/16/24 client #1 revealed: -He had lived at the facility for 3 months. -Fire and disaster drills were completed monthly. During interview on 05/15/24 client #2 revealed: -He had lived at the facility for 10 months. -He had completed fire drills, but he was uncertain how many times they had been completed. -He had completed tornado drills "sometimes." During interview on 05/16/24 client #3 revealed: -He had lived at the facility for 5 months. -He had completed a fire drill the first week he was there and last month. -He had not completed any disaster drills.	V 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 114	Continued From page 5 During interview on 05/16/24 client #4 revealed: -He had lived at the facility for 1 year. -With the exception of when the fire alarm went off on Saturday, he had not completed any planned fire and disaster drills recently. During interview on 05/20/24 client #5 revealed: -He had lived at the facility for 4 months. -He had done a couple of fire drills since he had lived at the facility and one tornado drill. During interview on 05/14/24 staff #1 revealed: -She had worked at the facility for 3 years. -She worked all three shifts. -The last fire drill was 5 months ago. -They did one on a Saturday because the fire alarm went off. During interview on 05/30/24 staff #2 revealed: -She had worked at the facility for almost 2 years. -The fire and disaster drills were supposed to be done every month. -The facility did a fire drill 2 1/2 weeks ago. During interview on 05/16/24 staff #3 revealed: -She had worked at the facility since July of 2023. -The facility did fire and disaster drills once a month. During interview on 05/16/24 Qualified Professional #1 revealed: -He had worked at the facility since October of 2023. -Fire drills were completed once a month and disaster drills were not completed "as often." During interview on 05/21/24 the Excutive Director revealed: -She had not done any fire or disaster drills.	V 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 114	Continued From page 6 -The staff completed the fire and disaster drills. -The staff were supposed to complete one fire drill per shift, per quarter. -Disaster drills were completed once a month. -The staff do tornado, bomb and hurricane drills each month. This deficiency constitutes a recited deficiency and must be corrected within 30 days.	V 114		
V 117	27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner.	V 117		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 117	Continued From page 7	V 117		

This Rule is not met as evidenced by:
Based on observation, record reviews and interviews, the facility failed to ensure that medications were labeled as required for 1 of 7 audited clients (#2). The findings are:

Review on 05/14/24 of client #2's record revealed:
-10 year old male.
-Admitted on 08/23/23.
-Diagnoses of Conduct Disorder,Attention Deficit Hyperactivity Disorder (ADHD), and Disruptive Mood Dysregulation Disorder (DMDD).

Review on 05/14/24 of client #2's signed physician review dated 05/5/24 revealed:
-Mupirocin Ointment 2% Apply topically three times daily for 7 days (skin infection).
-No order for Refresh Eye Drops.

Observation on 05/16/24 between 1pm - 1:30pm of client #2's medications revealed:
-Mupirocin Ointment did not have a label.
-Refresh Eye Drops did not have a label.

Interview on 05/28/24 the Registered Nurse stated:
-Client #2 was seen at an Urgent Care for a skin condition and Mupirocin Ointment was ordered for 7 days.
-Client #2 may have had "pink eye or dry eye at some point" but did not currently use any eye drops.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 117	Continued From page 8 This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type A1 rule violation and must be corrected within 23 days.	V 117		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 9 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure medications were administered as ordered by physician and the MARs were kept current for 4 of 7 audited current clients (#2, #3, #4, and #7) and 2 of 11 audited former clients (FC)(#9 and #12). The findings are: Cross Reference: 10A NCAC 27G .0209 Medication Requirements (V117) Based on observation, record reviews and interviews, the facility failed to ensure that medications for administration at the facility were labeled as required for 3 of 7 audited clients (#2). Cross Reference: 10A NCAC 27G .0209 Medication Requirements (V120) Based on observation, record review and interview, the facility failed to ensure medications were stored separately for 1 of 7 audited clients (#1). Cross Reference: 10A NCAC 27G .0209 Medication Requirements (V123) Based on record reviews and interviews, the facility failed to ensure all medication administration errors were immediately reported to a pharmacist or physician affecting 2 of 7 audited current clients (#2 and #4) and 2 of 11 audited former clients (FC) (#9 and #12). Finding #1 Review on 05/14/24 of client #2's signed physician order dated 05/05/24 revealed: -Cetirizine 10 mg 1 tablet daily (seasonal	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 10	V 118		

allergies).
-Fluticasone 50 micrograms (mcg) (allergy) 2 sprays in each nostril daily (seasonal allergies).
-Guanfacine 4 mg 1 tablet daily (ADHD).
-Qelbree 200 mg 1 capsule daily (ADHD).
-Mupiricon Ointment 2% Apply topically three times daily for 7 days (skin infection).

Review on 05/15/24 of client #2's January 2024 MAR revealed the following dates handwritten on the back of the MAR reflected the facility did not have medications (meds) to administer to client #2:
-01/16/24 - 01/18/24: Aripiprazole 10 mg - "meds not at the facility."
-01/01/24 - Azstarys 52.3-10.4 mg - "Hasn't come in from pharmacy."

Review on 05/15/24 of client #2's MAR from May 2024 revealed no initials on the following dates to indicate the medication had been administered:
-Aripiprazole 10 mg at 8pm on 05/08/24 - 05/12/24.
-Azstarys 52.3 - 10.4 mg at 8am on 05/11/24 - 05/13/24.
-Cetirizine 10 mg at 8am on 05/11/24 - 05/13/24.
-Fluticasone 50 micrograms at 8am on 05/11/24 - 05/13/24.
-Guanfacine 4 mg at 8am on 05/11/24 - 05/13/24.
-Qelbree 200 mg at 8am on 05/11/24 - 05/13/24.
-Mupiricon Ointment 2% at 8pm on 05/08/24.

Interview on 05/15/24 client #2 stated:
-He received his medications daily as prescribed.

Finding #2
Review on 05/14/24 of client #3's record revealed:
-17 year old male.
-Admitted on 02/02/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 11 -Diagnoses of Oppositional Defiant Disorder (ODD), CD, Major Depressive Disorder (MDD) Moderate Recurrent. Review on 05/15/24 of client #3's signed physician orders revealed: 04/18/24 -Abilify 10 mg (antipsychotic) take 1 tablet by mouth at bedtime. 05/06/24 -Abilify 15 mg take 1 tablet by mouth daily. Review on 05/15/24 of client #3's May 2024 MAR revealed: -Abilify 10 mg-D/C (discontinue) 05/06/24 was handwritten. -Abilify 15 mg was handwritten at the end of the MAR with one initial by staff on 05/06/24 at 8pm. -Abilify 15 mg-D/C 05/06/24 was handwritten. -No discontinue order was in the record signed by a physician to discontinue the Abilify 15mg. -No initials by staff on the MAR to indicate Abilify 10 mg or 15 mg was administered from 05/09/24-05/15/24. During interview on 05/16/24 client #3 revealed: -He had lived at the facility for 5 months. -He received his medication daily. -He had not missed any of his medication. -He was unsure if he took Abilify. -He knew what his medication looked like but did not know the names of the medication. During interview on 05/20/24 the facility's Registered Nurse (RN) revealed: -She had worked at the facility since 2009. -She was present at the facility at least 2 days a week. -Client #3's Abilify was increased from 10 mg to 15 mg when he was in the hospital.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 12 -She sent an email to the guardian to inform her of the increase in the medication. -The guardian and mother did not want the increase until client #3 had genetic testing done to determine which medications would work best for client #3. -She notified the facility physician to complete a discontinue order but she did not know if he remembered. -A check sheet was placed in the medication room to "make sure the MAR was completed correctly." -She did not "look back to see if staff were signing off on the MAR." Finding #3 Review on 05/21/24 of client #4's record revealed: -13 year old male. -Admitted on 01/04/24. -Diagnoses of DMDD, CD childhood onset type, ADHD combined type. Review on 05/15/24 of client #4's January 2024 MAR revealed handwritten on the back of the MAR were the following dates the facility did not have medications (meds) to administer to client #4: 01/08/24-"Risperidone Tab 1 mg Out of Stock." 01/15/24-"Clonidine 0.1 mg Out of Stock." 01/16/24-"Clonidine 0.1 mg Meds didn't arrive." 01/17/24-"Clonidine 0.1 mg Meds not at the facility." 01/30/24-"Naltrexone 50 mg Med not in facility." Finding #4 Review on 05/16/24 of client #7's record revealed: -16 year old male. -Admitted on 05/09/24.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 13 -Diagnoses of Unspecified Trauma and Stressor Related Disorder, ADHD and CD. Review on 05/20/24 of client #7's signed physician orders dated 05/02/24 revealed: -Metformin 500 mg (diabetes) 1 tablet twice daily. -Escitalopram 5 mg (depression) 3 tablets daily for anxiety. -Aripiprazole 10 mg (antipsychotic) 1/2 tablet twice daily for mood. Review on 05/16/24 of client #7's MARs from May 2024 revealed no staff initials on the following dates below to indicate the medication had been administered: -Metformin HCL 500 mg at 6pm on 05/11/24 and 05/12/24. -Escitalopram 5 mg on 05/11/24. -Aripiprazole 10 mg at 8pm on 05/11/24. Interview on 05/16/24 client #7 stated: -He received his medications daily. Interviews on 05/22/24 and 05/28/24 the RN stated: -Client #7 was admitted to the facility with Metformin. -Client #7 had lab work completed and his blood test did not indicate he was a diabetic. -Client #7 had an upcoming primary care appointment. Finding #5 Review on 05/14/24 revealed FC #9 did not have a record and the facility staff were unable to locate a record for FC #9. -Admission date of 04/17/23 was located on the January 2024 MAR. -No record of discharge date. -No diagnoses.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 14 -No physician orders for the following medications: Aptensio XR 40mg (ADHD) take 1 capsule by mouth every morning, Clonidine 0.1mg (ADHD) take 2 tablets by mouth every morning, Clonidine 0.1mg take 1 tablet by mouth every evening, Metformin 500mg (diabetes) take 1 tablet by mouth twice daily with meals, Quetiapine 300mg (schizophrenia) take 1 tablet by mouth twice daily and Vitamin D3 50mcg (supplement) take 1 tablet by mouth once daily. Review on 05/15/24 of FC #9's January 2024 MAR revealed handwritten on the back of the MAR were the following dates the facility did not have medications to administer to FC #9: -01/13/24-"Lithium 150 mg Out of Stock." -01/14/24-"Lithium 150 mg " " (meaning out of stock duplicated from 01/13/24)." -01/15/24-"Lithium 150 mg Out of Stock." -01/23/24-"Melatonin 6 mg Out of Stock." -01/24/24-"Melatonin 6 mg Out of Stock." -01/25/24-"Melatonin 6 mg Out of Stock." -01/26/24-"Melatonin 6 mg Out of Stock." -01/27/24-"Melatonin 6 mg Out of Stock." Finding #6 Review on 05/15/24 of FC #12's record revealed: -11 year old male. -Admission date of 02/14/23. -Unknown discharge date. -Diagnoses of ADHD, DMDD and CD. Review on 05/15/24 of the January 2024 MAR revealed handwritten on the back of the MAR were the following dates the facility did not have medications to administer to FC #12: -01/02/24-"Cetirizine 1mg Out of Stock." -01/06/24-01/11/24-"Cetirizine 1mg Out of Stock." -01/21/24-01/22/24-"Desmopressin 0.2mg Out of Stock."	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 15 -01/24/24-01/29/24-"Desmopressin 0.2mg Out of Stock Not in House." -01/31/24-"Desmopressin 0.2mg Out of Stock Not in House." FC #9 and #12 were unable to be interviewed due to being discharged from the facility and not having contact information. During interview on 05/20/24 the Pharmacist from the Pharmacy company the facility utilized revealed: -The facility received 2 deliveries a day of medication. -In the event that a medication was not available, the pharmacy sent out a blue sheet that identified the medication that was not available. -The facility was responsible to notify the pharmacy if they needed the medication that was not available so that the pharmacy could contact a secondary pharmacy in closer proximity to get the medication sooner. -The pharmacy had a primary number and a back-up number for the weekends to ensure availability. -He had no record of contact by the facility in relation to client #2, client #4, FC #9, and FC #13 having run out of medications. -He had no record of contact by the facility in relation to client #3 and #7 missing medications. -He had no record of any contact made to a backup pharmacy. -The facility should not have run out of Lithium 150mg for FC #9 from 01/13/24 - 01/15/24, as a 30 day order of Lithium (150mg) was sent out for FC #9 on 12/15/23 and again on 01/15/24. -He had "noticed at times facilities would wait till the medication had completely run out before requesting a refill." -The medications that were running out were	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 16 "common medications and those medications the pharmacy kept in stock." -It looked like the refill information was getting to the pharmacy late." Review on 06/18/24 of the Plan of Protection dated and signed on 6/18/24 by the Executive Director revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? 1. When medications are not available, the med tech (medical technician) will contact the nurse and Executive Director immediately so that medications are obtained from a local pharmacy. 2. Nurse will assess the medication cart today and ensure that all medications are labeled correctly. Nurse will ensure that all medications are stored appropriately by resident name as well as internal versus external medication. 3. Nurse will ensure that Pharmacist/Physician is notified immediately regarding a medication error. Nurse will document in the service record. Describe your plans to make sure the above happens. 1. All med techs will be inserviced today on notifying nurse and Executive Director immediately when medications are not available. 2. QP's will monitor daily per shift to ensure that all medications are administered as ordered and if any issues are noted will call the nurse and Executive Director. 3. Nurse will document in the medical chart all concerns/issues and any follow-up completed to ensure that the medical record is a complete document." The facility served clients from the ages of 10-17 years old with diagnoses of ADHD, DMDD, Conduct Disorder, Major Depressive Disorder. In the month of January 2024, client #2, client #4,	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 17 FC #9, and FC #12 had medications that were out of stock. Medications included Lithium, Clonidine, Cetirizine, Desmopression, Abilify, Risperidone and Azstrays. The facility had not requested refills in an adequate time before the medications would run out. The RN was not aware of the medications which ran out for each client. Client #3 was originally on Abilify 10mg and after a hospital visit the Abilify was increased to 15mg. The guardian did not agree to increase of the Abilify. The facility did not obtain a discontinue order for client #3's Abilify 15mg. The May 2024 MAR did not have initials by staff from 05/08/24-05/15/24 to indicate the medication had been administered for Abilify 10mg or 15mg. Client #5's Quetiapine 200 mg and Client #6's Clonidine 0.2 mg medications were stored together with client #1's medication. The facility did not have any documentation they contacted the pharmacist or physician for any medication errors which included the medications not being available due to being out of stock. Client #2 had a tube of Mupiricon ointment and a bottle of Refresh eye drops located in his medication slot that did not have labels to indicate client #2's name, directions for use of medication and the prescriber's information. Due to the systematic failure to ensure the clients received their medications and accurately document and store the medications this deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 118		
V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored:	V 120		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 120	Continued From page 18 (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure medications were stored separately for 3 of 7 audited clients (#1). The findings are: Review on 05/14/24 of client #1's record revealed: -17 year old male. -Admitted on 02/06/24. -Diagnoses of Major Depression Disorder, Recurrent, Mild, Conduct Disorder, Attention Deficit Hyperactivity Disorder (ADHD), Post Traumatic Stress Disorder (PTSD) and Cannabis Use Disorder Moderate in remission due to a secure environment. Review on 05/21/24 of client #5's record	V 120		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 120	Continued From page 19	V 120		

revealed:
-15 year old male.
-Admitted on 02/15/24.
-Diagnoses of ADHD combined type, Conduct Disorder adolescent onset type, PTSD by history, Disruptive Mood Dysregulation Disorder (DMDD) by history and Borderline Intellectual Functioning.

Review on 05/30/24 of client #6's record revealed:
-14 year old male.
-Admitted on 04/04/24.
-Diagnoses of DMDD, ADHD Unspecified Type, Reactive Attachment Disorder of Childhood. Mathematics Disorder and Specific Reading Disorder.

Observation on 05/14/24 between 1:30pm - 1:50pm of client #1's medications revealed:
-Client #6's Clonidine 0.2 mg tablet blister packs.

Observation on 05/15/24 between 11am - 11:15am of client #1's medications revealed:
-Client #5's Quetiapine 200 mg tablets and Client #6's Clonidine 0.2 mg tablet blister packs.

Interview on 05/15/24 staff #1 stated:
-She was unsure why client #5 and client #6's medications were in client #1's medications section.

Interview on 05/28/24 the Registered Nurse stated:
-She checked the medication cabinet at least once a week.
-She was at the facility 2 to 3 times a week.
-She had reorganized the medication cabinet because staff were "not watching where they put medications."
-Client medications were not put in the "right

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 120	Continued From page 20 spot." Interview on 05/21/24 the Director stated: -She had not been trained in medication administration. -She had not checked the medication cart. This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type A1 rule violation and must be corrected within 23 days.	V 120		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (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 reviews and interviews, the facility failed to ensure all medication administration errors were immediately reported to a pharmacist or physician affecting 2 of 7 audited current clients (#2 and #4) and 2 of 11 audited former clients (FC) (#9 and #12). The findings are:	V 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 123	Continued From page 21 Review on 05/14/24 - 05/21/24 of facility records revealed no documentation a physician or pharmacist had been notified immediately of medication administration errors for client #2, client #4, FC #9, and FC #12. Finding #1: Review on 05/15/24 of client #2's January 2024 Medication Administration Record (MAR) revealed the following medications were not available to be administered: -01/16/24 - 01/18/24: Aripiprazole 10 mg. -01/1/24 - Azstarys 52.3-10.4 mg. Review on 05/14/24 of client #2's signed physician order dated 05/05/24 revealed: -Aripiprazole 10 milligrams (mg) 1 tablet daily (mood disorder). -Azstarys 52.3 - 10.4 mg 1 capsule in the morning (Attention Deficit Hyperactivity Disorder)(ADHD). Finding #2: Review on 05/15/24 of client #4's physician orders revealed: 11/08/23 -Clonidine 0.1 mg (ADHD) take 1 tablet by mouth daily at bedtime and take 1 tablet by mouth every morning. 11/17/23 -Naltrexone 50 mg (treat alcohol use disorder and opioid use disorder) take 1 tablet by mouth once daily. 11/05/23 -Risperidone 1 mg (antipsychotic) take 1 tablet by mouth twice daily. Review on 05/21/24 of client #4's January 2024 MAR revealed the following medications were not available to be administered: -01/8/24: Risperidone 1mg.	V 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 123	Continued From page 22 -01/15/24 - 01/17/24: Clonidine 0.1mg. -01/30/24: Naltrexone 50mg. Finding #3: Review on 05/15/24 of FC #12's physician orders revealed no physician orders for the following medications: -Lithium 150mg -Melatonin 6mg. Review on 05/15/24 of FC #9's January 2024 MAR revealed the following medications were not available to be administered: -01/13/24 - 01/15/24: Lithium 150mg. -01/23/24 - 01/27/24: Melatonin 6mg. Finding #4 Review on 05/15/24 of FC #12's physician orders revealed: 05/31/23 -Cetirizine Solution 1mg/ml (milliliter) (allergies) Take 10ml by mouth once daily. 11/17/24 -Desmopressin 0.2mg (enuresis) Take 2 tablets by mouth daily at bedtime. Review on 5/15/24 of FC #12's January 2024 MAR revealed the following medications were not available to be administered: -01/2/24, 01/6/24 - 01/11/24: Cetirizine 1mg. -01/21/24 - 01/31/24: Desmopressin 0.2mg. Interview on 05/15/24 client #2 stated he had not missed any medications. Interview on 05/16/24 client #4 stated he had not missed any medications. FC #9 and #12 were unable to be interviewed due to being discharged from the facility and not	V 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 123	Continued From page 23 having contact information. Interview on 05/20/24 the Registered Nurse stated: -She was unaware that client #2, client #4, FC #9, and FC #12 were not administered their medications as ordered in January 2024. -She did not know why they were not have been administered their medications due to unavailability. -Staff were supposed to notify her when clients were out of medications and they had not notified her of these medications not being available. -The facility used a pharmacy located in nearby city and medications were delivered that night or the next morning. -Staff were supposed to fax over refill needs to the pharmacy several days prior to the medications being completed. -In the event that medications were not available at the pharmacy, the primary pharmacy would find a backup pharmacy to obtain the medications. Interview on 05/20/24 the Pharmacist stated: -He had no record of contact by the facility in relation to client #2, client #4, FC #9, and FC #12 running out of medications. Interview on 06/05/24 the Executive Director stated: -She was hired on 03/05/24. -She did not work with the medications. -She was unaware of the medication errors. This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type A1 rule violation and must be corrected within 23 days.	V 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 301	Continued From page 24	V 301		
V 301	27G .1801 Intensive Res. Tx. Child/Adol - Scope 10A NCAC 27G .1801 SCOPE (a) An intensive residential treatment facility is one that is a 24-hour residential facility that provides a structured living environment within a system of care approach for children or adolescents whose needs require more intensive treatment and supervision than would be available in a residential treatment staff secure facility. (b) It shall not be the primary residence of an individual who is not a client of the facility. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, severe emotional and behavioral disorders or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for acute inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to an intensive integrated treatment setting; and (2) treatment in a locked setting. (e) Services shall be designed to: (1) assist in the development of symptom and behavior management skills; (2) include intensive, frequent and pre-planned crisis management; (3) provide containment and safety from potentially harmful or destructive behaviors; (4) promote involvement in regular productive activity, such as school or work; and (5) support the child or adolescent in gaining the skills needed for reintegration into community living. (f) The intensive residential treatment facility	V 301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 301	Continued From page 25 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 observations, record reviews and interviews, the facility failed to provide treatment in a locked setting allowing potentially harmful and destructive behaviors to occur affecting 1 of 7 audited current client (#5) and 1 of 11 audited former client (FC) (#13) and the facility failed to coordinate with other individuals and agencies within the child or adolescent's system of care affecting 1 of 11 audited former client (#12). The findings are: Observation of the facility on 05/14/24 between 10:50am - 11:30am revealed: -A one story slab concrete building. -The back door was broken and could not latch and close. There was visible light from the outside between the door and the frame, from the handle to the bottom of the door. Finding #1 Review on 05/21/24 of client #5's record revealed: -15 year old male. -Admission date of 02/15/24. -Diagnoses of Attention Deficit Hyperactivity Disorder (ADHD) combined type, Conduct Disorder (CD) adolescent onset type, Post Traumatic Stress Disorder (PTSD) by history,	V 301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 301	Continued From page 26 Disruptive Mood Dysregulation Disorder (DMDD) by history and Borderline Intellectual Functioning. Review on 05/14/24 of FC #13's record revealed: -15 year old male. -Admission date of 08/24/23. -Discharge date of 02/26/24. -Diagnoses of ADHD combined type and CD. Review on 5/28/24 of the local police department police reports revealed: "2/18/24 at 17:15 (5:15pm)-On Sunday, February 18, 2024, I, [Officer #1] and [Officer #2] responded to a call located at [Facility address] in reference to a juvenile (client #5) who had left the facility. Upon arrival, [Officer #2] had located the juvenile outside of the facility rolling over a wooden bench belonging to the facility. [Officer #1] and [Officer #2] had immediately gotten out of our vehicles to approach the juvenile. The juvenile had advised that his name was [Client #5]. Myself (Officer #1) and [Officer #2] had started to make conversation with [Client #5] by asking him if he was okay, to which [Client #5] replied by stating that he was just tired of not being home and has been moving from facility to facility for years. [Client #5] also advised that he had gotten upset because the caretaker at the time, [Former Staff (FS) #5] had taken the remote control and had stated to [Client #5] that she did not 'give a f**k.' Myself (officer #1) and [Officer #2] had talked to him about his past and his plans for the future as [Client #5] calmed down and seemed to be really cooperative. [Client #5] eventually rolled the wooden bench back to where it was originally located. [Client #5] also advised that he would try to behave so that he can eventually go home with his mother, [Mother]. After talking with us for a while and realizing that we (myself (officer #1) and [Officer #2]) were just	V 301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 301	Continued From page 27	V 301		

there to make sure that [Client #5] was okay, [Client #5] agreed to go back into the facility." "-02/22/24 2106 (9:06pm)-On Thursday, February 23, 2024 officers [Officer #3] and [Officer #2] responded to an alarm activation on the fourth grade hallway at [Elementary School] at approximately 2110 hrs (9:10pm). On the left side of the school facing [Street] [Officer #3] noticed that a classroom window had been broken. Broken glass was on the inside of the classroom and outside of the school. A metal pipe was laying on the ground about three feet in front of the window. [Officer #3] investigated the physical crime scene and [Officer #2] went to check the security cameras. Unfortunately, there are no cameras aiming down that side of the building and flares from the security lights inhibit clear vision of anyone crossing the field at night. Officers (#2 and #3) left [Elementary School] to go to a call at 703 W. Third St (Carter Clinic's Renewing Grace facility) in reference to two juveniles ([Client #5]) [Date of Birth (DOB)] and [FC #13] [DOB]) who had run off. While there collecting information [Client #5] and [FC #13] were brought back to the facility by a male staff member. The juveniles had left the facility before the alarm was set off at [Elementary School]. [Officer #3] inspected that youth's (client #5's) shoes and discovered broken glass consistent with the broken glass at [Elementary School] in the soles of [Client #5's] shoes. When asked if they had done anything they could have gotten in trouble with the law for [FC #13] stated that he had broken a window with a pipe. Case Closed." "02/24/24 at 20:50 (8:50pm)-On 02/24/24 I, [Officer #4] was dispatched to 703 West 3rd Avenue in reference to a runaway missing juvenile. [Local County] Communications advised to me that the juvenile may possibly be in the area of [Elementary School]. I responded to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 301	Continued From page 28	V 301		

area of [Elementary School] to check for the juvenile prior to contacting the facility. I located the juvenile on [Street Address]. The juvenile was identified as [Client #5]. I placed [Client #5] in the right rear passenger seat of my patrol vehicle. I then transported [Client #5] back to [Facility Address] and spoke with a direct support staff person by the name of [Staff #2]. [Staff #2] stated that the front door to the facility is broken and can be opened by simply pulling on the door. [Staff #2] stated that she did not have a folder or file on [Client #5]. [Staff #2] stated that no supervisor was on sight and the key holder to the records was not on sight. Nothing further."

Review on 05/30/24 of the facility's maintenance work orders revealed:
09/27/24
-"Need the back door fixed in building A because one of the consumers broke it it will not close."
10/2/24
-"The backdoor to the facility is broken and need to be fixed."
02/4/24
-"The main front door knob needs to be tighten..."
02/4/24
-"Downstairs main entrance door needs locked door knob."

During interview on 05/20/24 client #5 revealed:
-He had lived at the facility for 4 months.
-He ran away from the facility with FC #13.
-He ran away 3 times.
-They ran through the woods and went to a school.
-They broke into the school by breaking a window.
-The school alarm went off and they ran.
-The front door was broken.
-"We just run out of the door."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 301	Continued From page 29 -All of his runaways "were in the same week." During interview on 05/30/24 client #1 revealed: -The doors of the facility were "always broken." -Client #5 and FC #13 "were always trying to run." -He saw the clients go through the office. -Clients used to be allowed to be in the office to listen to music and play on the computers. -The door knob on the front door had been kicked off. -Client #5 and FC #13 "ran out of the office door." -When they "broke out" of the facility they "tried to break into the school." During interview on 05/30/24 client #3 revealed: -"A client had hit the door knob with a cane and broke the door knob." -The door was broken for a "week or two." -FC #13 went outside and client #5 "played it off" like he was going to "fix the door" and client #5 "took off." During interview on 05/15/24 staff #1 revealed: -She had worked at the facility for 3 years. -The "back door had been broken for about 3 weeks." -Two clients had "ran out the front door and ran away" and broke into the "school house." During interview on 05/30/24 staff #2 revealed: -She had worked at the facility for approximately 2 years. -She felt like the facility had gone "down hill." -She had arrived at the facility on the day of the elopement (2/22/24) at approximately 5:00pm. -The older clients were in the office and the younger clients were in the therapy room. -The main door to get outside was broken. -She had walked to the kitchen and when she returned client #5 and FC #13 were "whispering	V 301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 301	Continued From page 30	V 301		

about the door being broken."
-Client #5 and client #13 "opened the door and ran out of the facility and cut through the back of the facility."
-She contacted the police and the Qualified Professional (QP).
-Client #5 was brought back to the facility by the police and FC #13 was brought back by a staff.
-The door was broken from a previous client.
-She did not know how long the door had been broken but it "happened often."
-The clients were "not supposed to be in the office but the computers were in the office and they wanted to play games."

During interview on 05/16/24 staff #3 revealed:
-She had worked at the facility almost a year.
-The back door of the facility had been "broken for 2 or 3 weeks."
-The "boys were always breaking the door."
-Client #5 and FC #13 "broke out of the facility and broke into a school."
-The incident occurred in February 2024.
-She was not working the day of the incident.

During interview on 05/21/24 staff #4 revealed:
-He had worked at the facility for 4 years.
-He was taken off the schedule due to an allegation and he just returned to work approximately a month ago.
-The back door was broken "when I came back to work."
-The door was "fixed and it was broken again."
-The middle part of the door "would not latch."

During interview on 06/4/24 the Maintenance staff revealed:
-He had done maintenance at the facility for 4 years.
-He knew the "front door was broken" but he was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 301	Continued From page 31	V 301		

unsure of the date and when the front door was fixed.
-"The back door had been broken like 5 times."
-Before the facility had a wood door.
-Now the facility had a metal door.
-The metal door was put up "a month ago."

Interview on 05/16/24 the QP #1 stated:
-The back door of the facility was fixed and it was broken again.
-The back door was "recently broken 2 or 3 days ago."
-The clients left out the back door when they had a behavior.
-The elopements of client #5 and FC #13 was a "breakdown of the system" with doors (front) not being locked and staff not using therapeutic holds.

Finding #2
Review on 05/15/24 of FC #12's record revealed:
-11 year old male.
-Admission date of 02/14/23.
-Unknown discharge date.
-Diagnoses of ADHD, DMDD and CD.

Review on 05/15/24 of FC #12's physician order dated 05/1/23 revealed:
-Pediasure Grow/Gain Strawberry Liquid Drink 1 container twice daily.

Review on 05/15/24 of FC #12's January 2024 MAR revealed the following dates FC #12 was not given Pediasure due to the facility not having the prescribed Pediasure:
-01/6/24-01/11/24-"Pediasure Out of Stock."
-01/19/24-01/22/24"Pediasure Out of Stock."
-01/29/24 "Pediasure Out of stock."

During interview on 05/28/24 the Registered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 301	Continued From page 32 Nurse (RN) revealed: -FC #12 "was underweight." -"She believes his weight was about 60 something pounds." -"He was taking pediasure for his weight." -"He was on medication that would cause him not to have an appetite." Review on 06/18/24 of the Plan of Protection dated 06/18/24 and completed and signed by the Executive Director revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? 1. Locked doors will be assessed today by Maintenance personnel. 2. If in need of repair, the maintenance personnel will repair today. 3. QP's will check all locked doors daily per shift and document. If in need of repair, staff will be assigned to monitor door until repaired. QP will call Executive Director for repair. Executive Director will contact maintenance immediately for repair and document work order in the system. Maintenance personnel will document date and time of repair. 4. Will inventory all supplements today and will ensure that all supplements are in stock in the facility today. -Describe your plans to make sure the above happens. 1. Facility Manager will monitor daily for needed repairs. Executive Director will monitor three times a week for repairs. 2. Facility Manager will monitor daily to ensure supplements are in the program. Executive Director will monitor three times a week to ensure supplements are in the program. Nurse will monitor weekly." The facility serves clients from the ages of 10-17	V 301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 301	Continued From page 33 years old with diagnoses of ADHD, DMDD, CD, Major Depressive Disorder and Intellectual Disability. The facility had not coordinated to ensure that FC #12 had received his Pediasure for 11 days. The facility had no systems in place to ensure care coordination of clients needs were met. On 05/14/24 the back door to the facility was broken and would not lock. Through interviews with facility staff and clients the back and front doors of the facility had been broken and did not lock and this was a continuous and ongoing issue. Client #5 and FC #13 were able to elope from the unlocked facility on 02/22/24 due to the front door being broken and broke into an elementary school through a window and caused damage to the window of the elementary school with a metal pipe. Client #5 also had two other elopements from the facility with police interaction from the unlocked facility. This deficiency constitutes a Continuing Type A1 rule violation originally cited for serious neglect for failure to correct within 23 days.	V 301		
V 305	27G .1805 Intensive Res. Tx. Child/ Adol - Operations 10A NCAC 27G .1805 OPERATIONS (a) Each facility shall serve no more than 12 children or adolescents. (b) Family members or other legally responsible persons shall be involved in development of plans in order to assure a smooth transition to a less restrictive setting. (c) Educational services within the facility shall be arranged and designed to maintain the educational and intellectual development of the child or adolescent. Treatment staff shall coordinate with the local education agency to ensure that the child or adolescent's educational	V 305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 305	Continued From page 34 needs are met as identified in the education plan. (d) Psychiatric consultation shall be available as needed for each child or adolescent. (e) If an adolescent has his 18th birthday while receiving treatment in the facility, he may remain for six months or until the end of the state fiscal year, whichever is longer. (f) Each child or adolescent shall be entitled to age-appropriate personal belongings unless such entitlement is counter-indicated in the treatment plan. (g) Each facility shall operate 24 hours per day, seven days per week, and each day of the year. This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to ensure the educational services were made available to meet the clients' needs for 7 of 7 current clients (#1, #2, #3, #4, #5, #6, and #7), and 8 of 11 audited former clients (FC) (#9, #10, #12, #13, #14, #17, #18 and #19). The findings are: Finding #1 Review on 05/14/24 of client #1's record revealed: -17 year old male. -Admitted on 02/06/24. -Diagnoses of Major Depressive Disorder (MDD), Conduct Disorder (CD), Attention Deficit Hyperactivity Disorder (ADHD),Post Traumatic Stress Disorder (PTSD), and Cannabis Use Disorder. -No documentation of educational services provided.	V 305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 305	Continued From page 35 -No documentation of coordination with the local education agency (LEA). Review on 05/14/24 of client #2's record revealed: -10 year old male. -Admitted on 08/23/23. -Diagnoses of CD, ADHD, and Disruptive Mood Dysregulation Disorder (DMDD). -No documentation of coordination with the LEA. Review on 05/15/24 of client #3's record revealed: -16 year old male. -Admitted on 02/2/24. -Diagnoses of Oppositional Defiant Disorder (ODD), PTSD, CD, and MDD. -No documentation of coordination with the LEA. Review on 05/21/24 of client #4's record revealed: -13 year old male. -Admitted on 04/26/23. -Diagnoses of DMDD, ADHD - Combined Type, and CD. -No documentation of coordination with the LEA. Review on 05/21/24 of client #5's record revealed: -15 year old male. -Admitted on 02/15/24. -Diagnoses of ADHD, CD, PTSD, DMDD, and Borderline Intellectual Functioning (BIF). -No documentation of coordination with the LEA. Review on 05/30/24 of client #6's record revealed: -14 year old male. -Admitted on 04/4/24. -Diagnoses of DMDD, ADHD Unspecified Type,	V 305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 305	Continued From page 36 Reactive Attachment Disorder of Childhood. Mathematics Disorder and Specific Reading Disorder. -IEP from former Psychiatric Residential Treatment Facility (PRTF) Meeting Date 01/8/24 From: 01/11/24 To: 01/10/25 revealed "Primary Eligibility: Emotional Disability...This environment is conducive to his mental health and educational needs within the PRTF environment. When he experiences a change in schools, this will need to be reviewed and revised to meet the environmental needs [client #6] presents at that time...Supplemental Aids/Services/Accommodations/Modifications: Social/Emotional Preferential seating [client #6] will sit in a location in the classroom that affords limited distractions and prompt intervention from staff as need to redirect his attention. All subjects..." -No documentation of coordination with the LEA. Review on 05/16/24 of client #7's record revealed: -16 year old male. -Admitted on 05/9/24. -Diagnoses of Unspecified Trauma and Stressor Related Disorder, ADHD and CD. -No documentation of educational services provided. -No documentation of coordination with the LEA. Review on 05/14/24 of FC #9's record revealed: -12 year old male. -Admitted 04/17/23. -No record of discharge date. -No record of diagnosis. -No information documented on educational needs. Review on 05/16/24 of FC #10's record revealed:	V 305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 305	Continued From page 37 -15 year old male. -Admitted 04/13/23. -Discharged 11/01/23. -Diagnoses of ADHD, Autism Spectrum Disorder, ODD, Unspecified Mood Disorder, and BIF. -No information documented on educational needs. Review on 05/15/24 of FC #12's record revealed: -10 year old male. -Admitted 02/14/23. -No discharge date available. -Diagnoses of ADHD, DMDD, ad CD. -No information documented on educational needs. -No documentation of coordination with the LEA Review on 05/14/24 of FC #13's record revealed: -16 year old male. -Admitted 08/24/23. -Discharged 02/26/24. -Diagnoses of ADHD - Combined Type and CD. -No information documented on educational needs. -No documentation of coordination with the LEA. Review on 05/14/24 of FC #14's record revealed: -18 year old male. -Admitted 02/21/23. -No discharge date available. -Diagnoses of ODD, ADHD - Combined Type, and BIF. -No information documented on educational needs. -No documentation of coordination with the LEA. Review on 05/20/24 of FC #16's record revealed: -13 year old male. -Admitted 04/25/23. -Discharged 06/8/23.	V 305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 305	Continued From page 38 -Diagnoses of CD, Unspecified Depressive Disorder, and ADHD. -No information documented on educational needs. -No documentation of coordination with the LEA. Review on 05/20/24 of FC #17's record revealed: -15 year old male. -Admitted 03/7/22. -Discharged 06/30/23. -Diagnoses of ADHD - Combined Type, ODD - Moderate, and PTSD. -No information documented on educational needs. -No documentation of coordination with the LEA. Review on 05/17/24 of FC #18's record revealed: -14 year old male. -Admitted 02/22/23. -Discharged 09/8/23. -Diagnoses of ADHD, CD, and Generalized Anxiety Disorder (GAD). -No information documented on educational needs. -No documentation of coordination with the LEA. Interview on 05/16/24 client #1 stated: -He had been at the facility for 3 months. -The school schedule alternated between 9am - 12pm or 12:45pm - 2:15pm every other day. -Exceptional Children's Teacher (ECT) #1 had everyone's educational records except his. -ECT #1 had him working on 9th grade work when he should be working on 10th grade work and he had no interest in repeating course work he had already completed. Interview on 05/15/24 client #2 stated: -The school schedule alternated between 9am - 12pm or 12pm - 2pm every other day.	V 305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 305	Continued From page 39	V 305		

-ECT #1 completed all lessons by video communications.
-He was in the 5th grade and all students received different assignments.

Interview on 05/16/24 client #3 stated:
-He had a new teacher (ECT #1) who had just started using video communications to complete classes.
-The daily schedule had changed last week.
-Prior to last week, clients were able to watch tv and go outside when there wasn't school.
-School was now Monday - Friday and was completed on the computer.
-Class schedule was 9am - 12pm for one group and 12:45pm - 2:15pm for the other group.

Interview on 05/16/24 client #5 stated:
-The school schedule alternated between 9am - 12pm or 12:45pm - 2pm every other day.
-Classes were Monday - Friday.
-ECT #1 started two Mondays ago (05/5/24) and conducted all classes by video communications.
-Former Exceptional Children's Teacher (FECT) #2 hadn't been at the facility for two months and was never on time.
-He was able to create an Internet channel during his education time.
-He never made a video on the channel he just created an account.

Interview on 05/16/24 client #7 stated:
-He had been at the facility for 8 days.
-School was going good but he felt it "can be better."
-He felt like he was doing 9th grade work.
-He was in the 10th grade.

Interview on 05/30/24 client #6 stated:
-"These people" (Qualified Professional #2 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 305	Continued From page 40 ECT #1) were trying to make him take his test with everyone else and he "needs to take my (his) test privately." Interview on 05/17/24 - 05/31/24 client #2's guardian stated: -Client #2 had been out of school from 03/22/24 - 05/06/24. -When asked about how school was going, client #2 told her that he hadn't been in school. -She inquired with the facility and was initially told by the Executive Director that the school was on Spring Break for "two weeks." -When she followed up with client #2 after the two weeks, he stated they still were not in school. -She again followed up at her next Child and Family Team (CFT) meeting about the break in education and was told that the facility had year round school and they were following the year round schedule. -She was notified sometime around March, 2023 that client #2 had been caught on the facility electronic tablet device during education time watching pornography. -She questioned how he had gained access to pornography on the facility electronic tablet device and notified the QP #1 of her concerns. -Since August of 2023, she had not received any report cards or progress reports on what Client #2 was working on, or any requested information about his educational progress. -The only information she had received was when FECT #2 would tell her if client #2 attended class. (05/29/24) -She had provided client #2's IEP and all accompanying forms and documentation when client #2 was admitted in August, 2023. She was informed in September, 2023 that the only documentation they had of client #2 was a copy of his social security card and birth certificate and	V 305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 305	Continued From page 41	V 305		

that they would need new copies of his documentation.
-She gathered the required documentation and provided it in paper form a second time in September, 2023.
-She had requested education progress and information from the facility for his discharge on 05/31/24 and was informed by ECT #1 that there was no previous information to provide before she started work at the facility in May, 2024, but she would be provided with client #2's progress for the month.
-She had been informed by the Executive Director of the Exceptional Children's Department (EDECD) for the county public school system that client #2 would be transitioning to that the district needed some account of client #2's time while at the facility and any assessments that might be needed.
-Due to the lack of documentation, absence of progress, and uncertainty about where client #2 was with regards to education, she had discussed with the EDECD for the county public school system to hold client #2 back a year and repeat the 5th grade in the fall.

During interview on 05/21/24 client #5's guardian revealed:
-As far as she understood he was not getting "much" education.
-He used a computer and was given papers.
-While he was using the computer he was able to sign in on to the Internet and made his own channel.
-Client #5 said they had a new teacher (ECT #1) and she would be doing an update to his education.
-When client #5 steps down he was going to have to know how to go to school.
-Client #5 did have an IEP and they told her they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 305	Continued From page 42 did not use the IEP and she did not understand why they would not use the IEP. Interview on 05/24/24 FC #10's Department of Social Services (DSS) guardian stated: -FC #10 was discharged from the facility in November, 2023. -She had difficulty getting any current information related to FC #10's educational progress when he was discharged. -She had made multiple requests with facility management and FECT #2 for FC #10's education documentation and was always told "we'll get that to you" but never received anything. -As a result of the missing educational information, FC #10 had to go "from the 10th grade back to the 9th grade" when he entered his new school. Interview on 05/30/24 the FECT #2 stated: -She kept all the educational documents with her because there was no where "secure" to keep them at the facility. -She had educational plans and treatment plans for all the clients at the facilty. -She transferred all the educational documents to the Residential Director and Licensee. -She had "coordination" with the LEA for clients #1, #2, #3, #4 and FC #9. -The client's educational progress was documented on their educational plans. Interview on 05/16/24 the ECT #1 stated: -She had worked at the facility about 4 weeks. -She had not had any coordination with the LEA. -Each student was supposed to have a representation from their prior school. -She had not had any contact with any prior school representative. -Most of the clients prior education documents	V 305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 305	Continued From page 43	V 305		

were from other treatment facilities.
-She did not have any school records for client #1.
-She determined client #1 should "start at the 9th grade" after "private conversation and assessment" with him.
-She had education plans for clients "in my head but not written down."

Interview on 06/5/24 ECT #1 stated:
-She had not been told about coordinating with the LEA.

Interview on 05/16/24 and 05/28/24 the QP #1 stated:
-Whatever was in the client book was what the facility had.
05/28/24
-He returned to work on 03/25/24 and former teacher #1 was no longer working at that time.
-There had been two teachers hired following former teacher #1's departure, but neither teacher made it beyond two weeks.
-ECT #1 teacher began on 05/02/24.
-Between 03/25/24 and 05/02/24, staff were going online and printing out material from the Internet for them to work on Individualized Education Programs (IEP) during the day.

Interview on 05/28/24 with the Interim Director for the Exceptional Children's Department for the local county school district stated:
-If IEPs were not being followed appropriately for clients with an IEP, it would "definitely impact their educational growth."
-Without targeted educational skills that are found in plans, "clients would fail to make the progress required to continue to advance advancing grade levels."
-In instances where the client is reintegrating into

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 305	Continued From page 44 a school system, "the school may have to conduct new assessments and evaluations to get an accurate gauge of where the the client is at academically." Interview on 05/28/24 QP #1 stated: -Client #2's guardian notified him on 03/25/24 of an incident where client #2 had gained access to pornography using the facility electronic tablet device during educational time. -The electronic tablet device browser history was checked and they were unable to retrieve any of browser history for that time period. -The electronic tablet devices were supposed to have had parental lock software already installed on them but were gathered and taken to the Information Technology (IT) department and reinstalled with new protection software. -The electronic tablet devices were only used during education time. Interview on 06/05/24 the Executive Director stated: -She did not receive any educational documents from former EC teacher #1. -She had asked about the documents "nobody really knew." -She had not received any information on coordination with the LEA. Finding #2 Review on 05/14/24 of the Exceptional Children's Teacher (ECT) #1 personnel record revealed: -Hire Date: 04/16/24. Review on 05/14/24 of the Former Exceptional Children's Teacher (FECT #2) personnel record revealed: -Hire Date: 09/12/22. -Date of Separation: 03/21/24.	V 305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 305	Continued From page 45 Review on 05/16/24 Former Staff (FS) #14's record revealed: -Hire date 03/25/24. -Resigned on 04/26/24. -Job: Paraprofessional. Interview on 05/17/24 FS #14 stated: -She worked at the facility about a month and half. -She resigned from the facility on 04/26/24. -There was no ECT. -Paraprofessional staff had to do school with the clients and provided clients with worksheets to complete. -She was unsure where the school worksheets came from. -Clients would work on school worksheets but "not long" it was "an hour at the most." -She had never seen any educational plans for the clients. Interview on 05/30/24 staff #2 stated: -She worked at the facility for 2 years. -She did not recall when FECT #2 left. -The clients were given "paperwork" the paraprofessional staff printed for school work. -The paperwork was information she found on the internet. -Paraprofessional staff did not have access to the client's Individualized Education Program (IEP) or educational plans. Interview on 05/30/24 FECT #2 stated: -Her last day teaching was the end of March. -Her last day "fully" teaching was between February and March. -She transitioned from the facility on April 1, 2024. -She was asked to be the Qualified Professional (QP) because another QP quit.	V 305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 305	Continued From page 46 -She did not recall the date she transitioned to a QP role, but it was after QP #1 quit. -She worked as the QP when Former EC Teacher #2 was hired. -Paraprofessional staff were not trained in education for the clients. Interview on 06/05/24 ECT #1 stated: -She had been the teacher since May 6, 2024. Interview on 06/05/24 the Executive Director stated: -She started part time on 03/05/24 and worked evenings. -When she started FECT #2 worked as the Qualified Professional (QP). -When FECT #2 's employment ended, QP #1 became the QP. -She was unsure what day the ECT #1 started. -She sent ECT #1 all the client's IEPs to review before she began teaching. -ECT #1 informed her the clients were on "break" because it was "private" school. Review on 06/18/24 of the Plan of Protection dated 06/18/24 and completed and signed by the Executive Director revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? 1. The residents will not have access to computers without staff supervision. Laptop computers will be removed from the facility on a daily basis. 2. Team will make contact with the local school district today to schedule a meeting. Team will attempt to schedule the meeting within the next two weeks. 3. Executive Director contact teacher today to review all IEP needs and will begin scheduling	V 305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 305	Continued From page 47 IEPs. Describe your plans to make sure the above happens. 1. School QP and Facility Manager will monitor daily. Executive Director will monitor three times a week. 2. Executive Director will monitor twice weekly. 3. Executive Director will monitor weekly until all IEPs are completed." The facility was licensed to provide intensive residential treatment for children and served clients with diagnoses to include Major Depressive Disorder, Attention Deficit Hyperactivity Disorder, Post Traumatic Stress Disorder and Borderline Intellectual Functioning. The clients ages ranged from 10 - 17 years old. The facility had not provided regular educational services to clients by an Exceptional Children's teacher. The facility's former teacher transitioned from the facility at the end of March. The facility depended on direct care staff to print educational worksheets which staff found online for the clients educational program for approximately 4 to 6 weeks. The direct care staff had no knowledge or training of the clients' educational needs. The facility did not have educational information to include IEPs for current clients. There were no current progress notes documented on the clients' education plans. The facility had not coordinated with the local education agency to ensure clients' educational needs were met. Following FC #10's discharge from the facility, the facility's lack of documentation of educational services and lack of coordination with the LEA resulted in FC #10's need to repeat grade 9 at a new school. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	Continued From page 48	V 366		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT 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	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	Continued From page 49 by: (1) immediately securing the client record by: (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	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	Continued From page 50 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 (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 review and interview, the facility failed to document their response to level II incidents. The findings are: Review on 05/28/24 of the local police department police reports revealed: -02/18/24 Client #5 eloped from the facility and police were contacted for assistance. -02/22/24 Client #5 and FC #13 eloped from the facility and broke into a elementary school with a metal pipe. Police were contacted for assistance. -02/24/24 Client #5 eloped from the facility and police were contacted for assistance. Review on 05/28/24 of the North Carolina (NC)	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	Continued From page 51 Incident Response Improvement System (IRIS) revealed: -There were no reports submitted by the facility for the incidents above. -There was no documentation to determine: The cause of the incident; If the facility developed and implemented corrective measures according to the provider specified timeframes not to exceed 45 days; no measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days and assigning person(s) to be responsible for implementation of the corrections and preventive measures. During interview on 05/21/24 the Executive Director revealed: -She had only been working at the facility for approximately a month. -She had discovered that some incident reports were not being submitted correctly. -She was not employed during the time of the incidents on 02/18/24, 02/22/24 and 02/24/24. During interview on 06/18/24 with the Executive Director and the Residential Director no response was given as to why the incident reports had not been completed for the incidents on 02/18/24, 02/22/24 and 02/24/24.	V 366		
V 367	27G .0604 Incident Reporting Requirements 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	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	Continued From page 52 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, 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	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	Continued From page 53 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) through (4) of this Paragraph.	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	Continued From page 54 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure an incident report was submitted to the Local Management Entity (LME)/Managed Care Organization (MCO) within 72 hours as required. The findings are: Review on 05/28/24 of the North Carolina Improvement Response Improvement System revealed: -There were no incident reports submitted for the police reports dated 02/18/24, 02/22/24 and 02/24/24. Review on 05/28/24 of the local police department police reports revealed: - "02/18/24 at 17:15 (5:15pm) On Sunday, February 18, 2024, I, [Officer #1] and [Officer #2] responded to a call located at [Facility address] in reference to a juvenile (client #5) who had left the facility. Upon arrival, [Officer #2] had located the juvenile outside of the facility rolling over a wooden bench belonging to the facility. [Officer #1] and [Officer #2] had immediately gotten out of our vehicles to approach the juvenile. The juvenile had advised that his name was [Client #5]. Myself (Officer #1) and [Officer #2] had started to make conversation with [Client #5] by asking him if he was okay, to which [Client #5] replied by stating that he was just tired of not being home and has been moving from facility to facility for years. [Client #5] also advised that he had gotten upset because the caretaker at the time, [Former Staff (FS) #5] had taken the remote control and had stated to [Client #5] that she did not 'give a f**k'. Myself (officer #1) and [Officer #2] had talked to him about his past and his plans for the future as [Client #5] calmed down and seemed to be really cooperative. [Client #5]	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	Continued From page 55	V 367		

eventually rolled the wooden bench back to where it was originally located. [Client #5] also advised that he would try to behave so that he can eventually go home with his mother, [Mother]. After talking with us for a while and realizing that we (myself (officer #1) and [Officer #2]) were just there to make sure that [Client #5] was okay, [Client #5] agreed to go back into the facility."
- "02/22/24 2106 (9:06pm)-On Thursday, February 23, 2024 officers [Officer #3] and [Officer #2] responded to an alarm activation on the fourth grade hallway at [Elementary School] at approximately 2110 hrs (9:10pm). On the left side of the school facing [Street] [Officer #3] noticed that a classroom window had been broken. Broken glass was on the inside of the classroom and outside of the school. A metal pipe was laying on the ground about three feet in front of the window. [Officer #3] investigated the physical crime scene and [Officer #2] went to check the security cameras. Unfortunately, there are no cameras aiming down that side of the building and flares from the security lights inhibit clear vision of anyone crossing the field at night. Officers (#2 and #3) left [Elementary School] to go to a call at 703 W. Third St (Carter Clinic's Renewing Grace facility) in reference to two juveniles ([Client #5]) [Date of Birth (DOB)] and [FC #13] [DOB]) who had run off. While there collecting information [Client #5] and [FC #13] were brought back to the facility by a male staff member. The juveniles had left the facility before the alarm was set off at [Elementary School]. [Officer #3] inspected that youth's (client #5's) shoes and discovered broken glass consistent with the broken glass at [Elementary School] in the soles of [Client #5's] shoes. When asked if they had done anything they could have gotten in trouble with the law for [FC #13] stated that he had broken a window with a pipe. Case Closed."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	Continued From page 56 - "02/24/24 at 20:50 (8:50pm)-On 02/24/24 I, [Officer #4] was dispatched to 703 West 3rd Avenue in reference to a runaway missing juvenile. [Local County] Communications advised to me that the juvenile may possibly be in the area of [Elementary School]. I responded to the area of [Elementary School] to check for the juvenile prior to contacting the facility. I located the juvenile on [Street Address]. The juvenile was identified as [Client #5]. I placed [Client #5] in the right rear passenger seat of my patrol vehicle. I then transported [Client #5] back to [Facility Address] and spoke with a direct support staff person by the name of [Staff #2]. [Staff #2] stated that the front door to the facility is broken and can be opened by simply pulling on the door. [Staff #2] stated that she did not have a folder or file on [Client #5]. [Staff #2] stated that no supervisor was on sight and the key holder to the records was not on sight. Nothing further." During interview on 5/21/24 the Executive Director revealed: -She had only been working at the facility for approximately a month. -She had discovered that some incident reports were not being submitted correctly. -She was not employed during the time of the incidents on 02/18/24, 02/22/24 and 02/24/24. During interview on 06/18/24 with the Executive Director and the Residential Director no response was given as to why the incident reports had not been completed/submitted for the incidents on 02/18/24, 02/22/24 and 02/24/24.	V 367		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 736	Continued From page 57 (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 and attractive manner. The findings are: Observation on 05/14/24 at approximately 11:00 am revealed: -A baseball size hole was partially covered by an outlet cover on the left wall entering the main living area. -Bathroom A had missing caulking around the top, left hand side of where the shower connected to the drywall. -Bathroom B had two overhead vents (approximately 16" x 16" square vent and 6" x 8" rectangular vent) that were completely covered with rust. -Bathroom B had a chrome overhead cover in the center of the bathroom that was approximately 5" in diameter that had rust covering 3/4 of the cover. -There was drywall damage visible on the top, left side of the shower/tub where the drywall met the shower/tub in bathroom B. The damage was approximately 1-2" in height and extended along the perimeter of the shower/tub. Caulking had separated around the left and right sides of the shower/tub, extending along the top perimeter of the shower/tub. -There were various stains of different shapes, sizes and colors on the ceiling in the common area. -There was several articles of clothing and shoes scattered throughout the floor of client #2 and client #4's bedroom.	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 736	Continued From page 58 Interview on 06/18/24 the Executive Director stated: -She would ensure repairs were completed. This deficiency constitutes a recited deficiency and must be corrected within 30 days.	V 736		
V 752	27G .0304(b)(4) Hot Water Temperatures 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit. This Rule is not met as evidenced by: Based on observation and interviews, the facility water temperatures were not maintained between 100-116 degrees Fahrenheit in areas where clients were exposed to hot water. The findings are: Observation on 05/14/24 at approximately 11:00 am revealed: -The hot water temperature in bathroom #1 was 122 degrees Fahrenheit at the sink. -The hot water temperature in bathroom #2 was 120 degrees Fahrenheit at the sink. Clients #1, #2, #3, and #5 stated that they had not observed any problems with the water	V 752		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-325	A. BUILDING: _____ B. WING _____	R 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWING GRACE RESIDENTIAL HOME	703 WEST 3RD AVENUE, BUILDING A RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 752	Continued From page 59 temperature. Interview on 05/14/24 staff #1 stated: -She had not observed any problems with water temperatures. -Clients had stated to her that the water temperatures were not "hot enough." Interview on 05/28/24 Qualified Professional #1 stated: -He had not observed any problems with water temperatures. Interview on 05/24/24 and 06/18/24 the Executive Director stated: -She was unaware of any problems with water temperatures. -She had the bathrooms in question closed off and maintenance had adjusted the water temperatures. -She had checked the following day and the temperatures were still "a little high." -Maintenance was called a second time and stated the knob which adjusted the water had been moved. -A plumber was called out and had repaired the water heater. -Moving forward, management were required to make daily checks on the water temperatures to ensure proper temperatures were maintained. This deficiency has been cited five times since the original cite on 02/02/22 and must be corrected within 30 days.	V 752		