Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	240138	A. BUILDING: ______ B. WING ______	R-C 08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHER ASPIRATION BEHAVIORAL HEALTH C	204 8TH STREET OXFORD, NC 27565

(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 8/13/24. The complaint was substantiated (intake #NC00218256). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 4 and has a current census of 4. The survey sample consisted of audits of 1 current client & 3 former clients.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid	V 108		

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techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction.
(i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to ensure 3 of 7 staff (#3, #4 & #7) had current first aid/cardiopulmonary resuscitation (CPR). The findings are:

Review on 8/9/24/24 of staff #3's personnel record revealed:
- hire date: 11/1/22
- first aid/CPR expired 1/2024

Review on 7/22/24 of staff #4's record revealed:
- hire date: 4/8/22
- first aid/CPR expired 1/28/21

During interview on 8/13/24 staff #4 reported:
- his first aid/CPR was not current
- he came from his previous employment with first aid/CPR
- had not been retrained in first aid/CPR since he worked at the facility

Review on 8/9/24 of staff #7's personnel record revealed:
- hire date: 5/23/24
- first aid/CPR expired April 2023

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V 108	Continued From page 2 During interview on 8/8/24 the Licensed Professional/Owner reported: - was not able to get in contact with the person that completed staff #3, #4, & #7s' current CPR training - the CPR training was completed at the same time the staff's restrictive intervention was completed (6/25/24)	V 108		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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This Rule is not met as evidenced by:
Based on record review and interview the facility failed to develop and implement treatment plans for 2 of 4 former clients (FC#5 and FC#6). The findings are:

Review on 7/22/24 of FC#5's record revealed:
- age 12 years old
- admitted 10/11/23 and discharged 6/21/24
- diagnoses: Attention Deficit Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder
- a treatment plan dated 8/30/23 updated on 2/1/24: "...will identify triggers to learn and implement healthy/effective coping strategies to manage anger in all settings (will use CPI (Crisis Prevention Institute) holding skills to help clients manage difficult situations and disruptive behaviors ....will use CPI holding when a client is in crisis and to help avoid any injuries...)"

Review on 7/22/24 of FC#6's record revealed:
- admitted 5/9/24 & 6/10/24
- diagnoses: ADHD and Post Traumatic Stress Disorder
- a treatment plan dated 4/26/24: "...will reduce instances of physical/verbal aggression against staff/peers by no more than four outburst per week (CPI interventions to be utilized when client is hurting self, others or engaging in extreme property destruction) "

Review between 7/22/24 - 8/9/24 of staff's

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V 112	Continued From page 4 personnel records revealed they were trained in restrictive intervention Handle with Care (HWC) During interview on 8/13/224 the Licensed Professional/Owner reported: - staff were trained in HWC	V 112		
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. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure disaster drills were completed on each shift and quarterly. The	V 114		

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findings are:

Review on 7/19/24 of the facility's disaster drill book revealed:
- disaster drills were not completed within the last year

During interview on 7/19/24 the Licensed Professional/Owner (LP/O) reported the shifts as follows:
- 8am - 4pm (first)
- 4pm - 12am (second)
- 12am - 8am (third)

During interview on 7/19/24 client #1 reported:
- admitted to facility 3/2024
- had not practiced a tornado drill
- his mom told him to get in the bathroom tub during a tornado

During interview on 8/13/24 client #3 reported:
- admitted to the facility Tuesday (8/6/24)
- had not practiced a tornado drill
- was not sure what he would do during a tornado

During interview on 8/13/24 client #4 reported:
- admitted to the facility on Friday (8/9/24)
- had not practiced a tornado drill
- would get in the bathroom tub during a tornado

During interview on 7/19/24 staff #1 reported:
- she filled in at the facility
- had not completed a tornado drill
- clients would get in the closet if there was a tornado

During interview on 7/22/24 staff #3 reported:
- he worked 2 days a week from 8am - 4pm

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V 114	Continued From page 6 - had not completed tornado drills on his shift - would have the clients kneel down in the bathroom in case of a tornado During interview on 8/8/24 staff #9 reported: - his shifts varied - had not completed any tornado drills - during a tornado, clients would get under the kitchen table Observation on 7/19/24 at 1:53pm of the kitchen revealed: - a brown wooden kitchen table with 4 chairs up were against the kitchen wall During interview on 8/13/24 the Qualified Professional reported: - he was responsible for ensuring drills were completed - was not aware disaster drills had to be completed - staff should take the clients in the bathroom if there was a tornado During interview on 7/19/24 the Licensed Professional/Owner reported: - was not aware disaster drills had to be done - only thought fire drills had to be done - a staff meeting will be held to discuss tornado drills - will discuss how to conduct and the location for tornado drills This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 114		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION	V 118		

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V 118	Continued From page 7 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. This Rule is not met as evidenced by: Based on record review and interview the facility failed to administer 2 of 4 current clients (#2 & #3) & 2 of 4 former clients (FC#6 & FC#7)'s	V 118		

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medications on the written order of a physician. The findings are:

A. Review on 8/13/24 of client #2's record revealed:
- age 14 years old
- admitted 8/9/24
- diagnosis: Attention Deficit Hyperactivity Disorder (ADHD)
- no physician's orders for the following medications:
- Escitalopram 10mg (milligram) daily (depression)
- Guanfacine 3mg everyday (ADHD)
- Lisdexamfetamine 40mg daily (ADHD)
- Aripiprazole 10mg everyday (mood disorder)

Review on 8/13/24 of client #2's August 2024 MAR revealed:
- staff initialed the above medications as administered from 8/9/24 - 8/13/24

During interview on 8/13/24 the Licensed Professional/Owner (LP/O) reported:
- client #2 was admitted from his home with only his medications
- client #2 had an upcoming medication appointment

B. Review on 8/13/24 of client #3's record revealed:
- age 15 years old
- admitted 8/6/24
- diagnosis: ADHD
- no physician orders for the following medications:
- Dexmethylphenidate 10mg morning (ADHD)
- Guanfacine 2mg twice daily (ADHD)
- Clonidine .2mg bedtime (ADHD)
- Melatonin 3mg bedtime (sleep aid)

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Review on 8/13/24 of client #3's August 2024's MAR revealed:
- staff initialed the above medications as administered from 8/7/24 - 8/13/24

During interview on 8/13/24 the LP/O reported:
- client #3 was admitted from another level III facility with the MAR & prepackaged medications

C. Review on 7/22/24 & 7/25/24 of FC#6's record revealed:
- age 10 years old
- admitted 5/9/24 and discharged 6/10/24
- diagnoses: ADHD and Post Traumatic Stress Disorder (PTSD)
- no physician orders for the following medications:
- Methylphenidate 54mg daily (ADHD)
- Sertraline 50mg daily (PTSD)
- Trazodone 50mg one half by mouth nightly (Qhs) (depression)
- Desmopressin 0.2mg 2 Qhs (bedwetting)
- Guanfacine 1mg 2 Qhs (ADHD)

Review on 7/25/24 of FC#5's May 2024 & June 2024 MARs revealed:
- May 2024 MAR: staff initialed above medications as administered from 5/8/24 - 5/31/24
- June 2024 MAR: staff initialed above medications as administered from 6/1/24 - 6/10/24

During interview on 7/24/24 the Department of Social Services (DSS) guardian for FC#5 reported:
- FC#5 was admitted to the facility with his medications only, no physician's orders
- he was admitted from a respite facility

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- told the LP/O he could have taken FC#5 to the emergency room to get physician's orders for the medications

During interview on 7/24/24 the LP/O reported:
- FC#2 was admitted without physician orders
- DSS did not follow through with getting paperwork to FC#5's primary physician to get medication management setup
- was not able to get the physician orders without the paperwork from DSS

D. Review on 7/22/24 & 8/1/24 of FC#7's record revealed:
- age 17 years old
- admitted 7/17/24/24 and discharged 7/29/24
- diagnoses: PTSD & Oppositional Defiant Disorder
- no physician's orders for the following medications:
- Lisinopril 20mg 1/2 everyday (blood pressure)
- Cetirizine 10mg daily (allergy)
- Vitamin D3 3000 daily (multivitamin)
- Triamcinolone 25% as needed (dermatitis)

Review on 8/1/24 of FC#6's July 2024 MAR revealed:
- staff initialed medications as administered from 7/23/24 - 7/29/24

During interview on 7/31/24 the LP/O reported:
- FC#7 was admitted with physician's orders
- when he was discharged, the physician's orders were given to the guardian
- he did not keep copies of the physician's orders

This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.

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V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring	V 296		

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supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan.

This Rule is not met as evidenced by:
Based on observation, record review and interview the facility failed to ensure 2 direct care staff were present for 2 of 4 current clients (#1 & #2) and 4 of 4 former clients (FC#4, FC#5, FC#6 & FC#7). The findings are:

Review on 7/19/24 of client #1's record revealed:
- age: 15 years old
- admitted 3/19/24
- diagnosis: Adjustment Disorder with mixed disturbance

Review on 8/13/24 of client #2's record revealed:
- age: 15 years old
- admitted 8/9/24
- diagnosis: Attention Deficit Hyperactivity Disorder (ADHD)

Review on 7/22/24 of FC#4's record revealed:
- age: 15 years old
- admitted 6/10/23 and discharged 7/15/24
- diagnoses: Conduct Disorder and Post Traumatic Stress Disorder (PTSD)

Review on 7/22/24 of FC#5's record revealed:
- age: 12 years old

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- admitted 10/11/23 and discharged 6/21/24
- diagnoses: ADHD and Oppositional Defiant Disorder

Review on 7/22/24 of FC#6's record revealed:
- age: 10 years old
- admitted 5/9/24 and discharged 6/10/24
- diagnoses: PTSD and ADHD
- facility's face sheet with no date: "...walked away from previous placement 2 times in last year...where did he go: down the street..."
- a treatment plan dated 4/26/24: goal: no absence without official leave (AWOL) attempts

Review on 8/1/24 of FC#7's record revealed:
- age: 17 years old
- admitted 7/17/24 and discharged 7/29/24
- diagnosis: PTSD

During interview on 7/19/24 the LP/O reported the shifts were as follows:
- 8am - 4pm (first)
- 4pm - 12am (second)
- 12am - 8am (third)

During interview on 7/19/24 client #1 reported:
- since FC#4 left, sometimes he was alone with 1 staff

During interview on 8/13/24 client #2 reported:
- today (8/13/24) staff #2 arrived to the facility at 5:50am and left at 11am
- he looked at the clock when she arrived to the facility this morning
- client #1 and client #3 were in school
- he was alone with staff #4

During interview on 7/23/24 & 8/13/24 staff #4 reported:
- on 7/23/24, he did not work alone "often"

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHER ASPIRATION BEHAVIORAL HEALTH C	**204 8TH STREET OXFORD, NC 27565**

(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
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- this past weekend (7/20/24 - 7/21/24) he worked first shift alone on Saturday & Sunday
- staff #7 relieved him at 4pm on Sunday
- she was the only staff at the facility when he left
- on 8/13/24, staff #2 had to leave early due to an appointment
- he called the LP/O & made him aware staff #2 left early
- there were times he did not notify management when someone called out
- there were no issues on his shift when he worked alone

During interview on 7/19/24 staff #2 reported:
- worked first shift
- had worked alone with client #1
- yesterday (7/18/24) she worked an 1 1/2 hours alone on shift with client #1
- worked alone due to a staff that called out

During interview on 7/22/24 staff #7 reported:
- worked second shift
- had worked alone with client #1 twice
- worked Saturday and Sunday (7/20/24 - 7/21/24) alone with client #1
- staff #9 relieved her at 12am Sunday
- when she left, he was the only staff on duty
- no issues when she worked alone

During interview on 8/8/24 staff #9 reported:
- worked second and third shift
- worked third shift "alone sometimes"
- the clients were asleep when he arrived on shift
- in the last 3 months, he "worked alone 50% of the time" on third shift
- sometimes he was scheduled to work alone on third shift and other times staff called out
- if a staff called out, he (staff #9) reached out

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to another staff to fill in or he contacted the Qualified Professional (QP)

During interview on 7/31/24 staff #6 reported:
- 2 - 3 months ago FC#6 eloped on second shift and she was the only staff on duty
- was present with 3 other clients (client #1, FC#4 and FC#5)
- another staff had called out of work that day
- could not recall why FC#6 had eloped but knew he wanted his way that day
- he "took off" to the local department store
- she did not go behind him, because she had 3 other clients at the facility
- she called the police and the QP
- the QP returned FC#6 to the facility within 15 minutes
- worked "approximately twice alone" with all 4 clients
- she had worked 3 - 4 times alone with client #1
- there had been no other issues on her shift
- the clients "respected" her

Observation on 8/13/24 revealed:
- at 7:24pm: local department store was .5 mile from the facility
- a busy 4 way intersection to get to the local department store
- no sidewalk for a pedestrian to walk on

During interview on 8/7/24 staff #3 reported:
- worked first shift but filled in on third shift
- had worked "once or twice alone within the last couple of months"
- had worked alone one day with client #1
- worked alone one day with client #1 & FC#7
- the clients were asleep on third shift with no issues

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During interview on 7/19/24 & 8/13/24 the QP reported:
- "there were times" 1 staff was at the facility alone due to a staff "call outs"
- he lived an hour away, therefore staff were supposed to contact him to fill in
- on 8/13/24, staff had a set weekly schedule
- 2 staff were scheduled for first, second and third shifts
- "due to staff shortage, there were times 1 staff was scheduled for third shift"
- he thought ongoing staff shortage had been since March 2024
- was off work today (8/13/24) and was not aware of any staff "call outs"
- management was constantly hiring but staff received "1 check and they quit"

During interview on 7/23/24 & 8/13/24 the Licensed Professional/Owner reported:
- 2 people were scheduled on shift at all times
- staff would call out, however, him and the QP lived 30 minutes away, staff could call them and they would fill in
- the staff were supposed to first contact the QP if staff did not show up to work
- if the QP was not available, staff would call him (LP/O)
- had not worked a shift because the QP filled in on the shifts
- on 8/13/24, he was not aware staff #2 left early today (8/13/24)
- for the last 2 -3 weeks, he thought staff #9 & staff #10 were on third shift together
- staff #3 filled in on third shift but he recently resigned from the job
- the QP handled the staff schedules
- unless the QP notified him, he was not aware of staff schedules or staff call outs
- he and the QP would meet to address staff

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V 296	Continued From page 17 call outs and 2 staff being scheduled on all shifts This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. Review on 8/13/24 of the Plan of Protection dated 8/13/24 written by the LP/O revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? As of August 13, 2024, Higher aspiration managing will meet daily regarding operation and staffing. Higher Aspiration (Licensee) will proceed to conduct interviews, as well as hire as frequent to insure appropriate staff on all shifts. If staffing is not covered administration will be notified and management will agree to cover the remainder of the shift. Describe your plans to make sure the above happens. The [LP/O] and [QP] will enforce this plan." Clients' ages ranged from 10 - 15 years old with diagnoses of ADHD, Oppositional Defiant Disorder, PTSD and Conduct Disorder. There were multiple times staff worked alone with 1 - 4 clients. On one occasion, staff #6 worked alone with 4 clients and FC#6 eloped for 15 minutes to a local department store a half mile from the facility. The department store was located near a busy four way intersection with no sidewalks for pedestrians. Since March 2024, there were unknown times the QP scheduled 1 staff for third shift. The LP/O and QP were supposed to be contacted when staff called out, but staff worked alone without notifying management. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients and must be corrected within 45 days.	V 296		

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V 366	Continued From page 18	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		

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V 366	Continued From page 19 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		

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V 366	Continued From page 20 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 implement their incident reporting policy. The findings are: Review of facility records on 7/25/24 revealed no documentation the facility documented their response to the following: - (former client) FC#5 & FC#6's restraints - FC#6 & FC#7's elopement from the facility Refer to V367 regarding details of incidents that occurred at the facility: - FC#5 & FC#6's were placed in unapproved restraints at the facility - FC#6 & FC#7's elopement from the facility	V 366		

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V 366	Continued From page 21 and the police had to be called During interview on 8/13/24 the Qualified Professional reported: - the Licensed Professional/Owner (LP/O) investigated the incidents - the (LP/O) submitted the incident reports in the IRIS system During interview on 8/13/24 the LP/O reported: - the QP investigated any incidents that happened at the facility - he (LP/O) submitted the incidents in the IRIS system	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 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;	V 367		

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V 367	Continued From page 22 (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 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.	V 367		

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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.

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to complete a level II incident report to the Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours. The findings are:

Review on 7/19/24 of the Incident Response Improvement System (IRIS) revealed:
- no level II reports from the facility

Review on 8/6/24 of the 911 police call log revealed: no documentation for elopements

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V 367	Continued From page 24 A. Review on 7/24/24 of an email from (former client) FC#6's Care Coordinator to the Division of Health Service Regulation revealed: - email dated 6/10/24 from the Licensed Professional/Owner (LP/O) to FC#6's Care Coordinator: "...[FC#6] elopement attempt in which the police has to be called..." B. Review on 7/25/24 of the facility's ABC data sheet for (FC#5 & FC#6) revealed the following: - restraints for FC#5: - 2/19/24 - "SIB (self inflicted behaviors)" punching himself in the face, cursing at staff...redirected/restraint ...aggression" staff #3 - 2/20/24 - "...got mad curse, he couldn't take [FC#3]'s football outside...redirected/restraint " staff #3 - 5/15/24 - "...SIB, cursing, attempting to fight peer, fighting staff, hitting self all about the face, punching, kicking the wall floor and head butting the floor...management contacted...redirected/restraint/PRN" staff #3 - 5/23/24 - "...SIB - got upset tossing his markers and pencils destructively...restraint/contacted [QP]" staff #3 - 5/25/24 - "...was told several times stop talking and go to sleep. He ignored staff and continued talking. Staff assisted for [FC#2] to come into the living room so his roommate can go to sleep. He began to curse at staff, hit walls, doors and fight...restraint/contacted [QP]" staff #9 - restraint for FC#6 revealed the following: - 6/9/24 "... ripping socks, pull a pole from under his bed, cussing, yelling tried to hit staff with pole...restraint..." staff #7 During interview on 7/19/24 & 8/13/24 the LP/O reported: - he completed incident reports for the elopements and submitted them through IRIS	V 367		

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V 367	Continued From page 25 - the restraints were documented on an in-house form - it was his first time and "possibly" did not submit the incident reports correctly - he would follow up with the LME/MCO This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 367		
V 518	27E .0104(e1-2) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (1) the requirement that positive and less restrictive alternatives are considered and attempted whenever possible prior to the use of more restrictive interventions; (2) consideration is given to the client's physical and psychological well-being before, during and after utilization of a restrictive intervention, including: (A) review of the client's health history or the client's comprehensive health assessment conducted upon admission to a facility. The health history or comprehensive health assessment shall include the identification of pre-existing medical conditions or any disabilities and limitations that would place the client at greater risk during the use of restrictive interventions; (B) continuous assessment and monitoring of the physical and psychological well- being of the client and the safe use of restraint throughout the duration of the restrictive intervention by staff	V 518		

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who are physically present and trained in the use of emergency safety interventions;
(C) continuous monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being during the use of manual restraint; and
(D) continued monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being for a minimum of 30 minutes subsequent to the termination of a restrictive intervention;

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to ensure of 2 of 4 former clients (FC#5 & FC#6) were continually monitored by an individual trained in the use of cardiopulmonary resuscitation (CPR) of the client's physical and psychological well-being for a minimum of 30 minutes subsequent to the termination of a restrictive intervention. The findings are:

Review on 8/9/24/24 of staff #3's personnel record revealed:
- hire date: 11/1/22
- first aid/CPR expired 1/2024

Review on 8/9/24 of staff #7's personnel record revealed:
- hire date: 5/23/24
- first aid/CPR expired April 2023

Review on 7/22/24 of FC#5's record revealed:
- age 11 years old
- admitted 10/11/23 and discharged 6/21/24
- diagnoses of Attention Deficit Hyperactivity

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Disorder (ADHD) & Oppositional Defiant Disorder

Review on 7/22/24 of FC#6's record revealed:
- age 10 years old
- admitted 5/9/24 and discharged 6/10/24
- diagnosis: Post Traumatic Stress Disorder and ADHD

During interview on 8/7/24 staff #3 reported:
- he conducted restraints several times on FC#5
- he stood behind FC#5 and crossed FC#5's arms in front of him
- the restraint lasted 2 - 3 minutes

During interview on 8/7/24 staff #7 reported:
- she placed FC#6 in a restraint
- she went behind him and placed his hands beside him until he calmed down
- the restraint lasted less than 5 minutes

During interview on 8/13/24 the Qualified Professional reported:
- staff contacted him after a restraint was conducted
- he came to the facility & interviewed staff & client
- observed client for marks and bruises
- investigated to see why the restraint was done and did staff attempt to de-escalate the situation
- he did not document his debriefing with staff & client

During interview on 8/8/24 the Licensed Professional/Owner reported:
- was not able to get in contact with the person that completed staff #3 & #7s' current first aid/CPR training
- the QP was responsible for the debriefing &

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V 518	Continued From page 28 documentation after a restraint	V 518		
V 521	27E .0104(e9) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (9) Whenever a restrictive intervention is utilized, documentation shall be made in the client record to include, at a minimum: (A) notation of the client's physical and psychological well-being; (B) notation of the frequency, intensity and duration of the behavior which led to the intervention, and any precipitating circumstance contributing to the onset of the behavior; (C) the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used; (D) a description of the intervention and the date, time and duration of its use; (E) a description of accompanying positive methods of intervention; (F) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions; (G) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and	V 521		

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(H) signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention.

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to ensure whenever a restrictive intervention was utilized, documentation was in the clients' records for 2 of 4 former clients (FC#4 & FC#5)'s records. The findings are:

Review on 7/22/24 of FC#5's record revealed:
- age 12 years old
- admitted 10/11/23 and discharged 6/21/24
- diagnoses: Attention Deficit Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder
- no documentation of the following:
- notation of the client's physical and psychological well-being;
- duration of its use
- a description of accompanying positive methods of intervention;
- a description of the debriefing and planning with the client and the legally responsible person,
- signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention.

Review on 7/22/24 of FC#6's record revealed:
- age 10 years old
- admitted 5/9/24 and discharged 6/10/24
- diagnoses: Post Traumatic Stress Disorder and ADHD
- no documentation of the following:
- notation of the client's physical and psychological well-being;
- duration of its use

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- a description of accompanying positive methods of intervention;
- a description of the debriefing and planning with the client and the legally responsible person,
- signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention.

Review on 7/25/24 of the facility's ABC data sheet for FC#5 & FC#6 revealed the following:
- restraints for FC#5:
- staff initials documented & their signatures
- 2/19/24 - "SIB (self inflicted behaviors)" punching himself in the face, cursing at staff...redirected/restraint ...aggression" staff #3
- 2/20/24 - "...got mad curse, he couldn't take [FC#3]'s football outside...redirected/restraint " staff #3
- 5/15/24 - "...SIB, cursing, attempting to fight peer, fighting staff, hitting self all about the face, punching, kicking the wall floor and head butting the floor...management contacted...redirected/restraint/PRN (as needed)" staff #3
- 5/23/24 - "...SIB - got upset tossing his markers and pencils destructively...restraint/contacted Qualified Professional [QP]" staff #3
- 5/25/24 - "...was told several times stop talking and go to sleep. He ignored staff and continued talking. Staff assisted for [FC#2] to come into the living room so his roommate can go to sleep. He began to curse at staff, hit walls, doors and fight...restraint/contacted [QP]" staff #9
- restraint for FC#6 revealed the following:
- 6/9/24 "... ripping socks, pull a pole from under his bed, cussing, yelling tried to hit staff with pole...restraint..." staff #7

During interview on 8/13/24 the QP reported:

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V 521	Continued From page 31 - staff contacted him after a restraint was conducted - he came to the facility & interviewed staff & client the reasons for the restraint - he debriefed with the client - he did not document the debriefing During interview on 8/13/24 the Licensed Professional/Owner reported: - the QP was responsible for the debriefing & documentation after a restraint - he reviewed the facility's ABC log but did not review for the debriefing of the clients	V 521		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of	V 537		

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V 537	Continued From page 32 training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain	V 537		

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V 537	Continued From page 33 documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and	V 537		

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(D) documentation procedures.
(7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule.
(8) Trainers shall be currently trained in CPR.
(9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach.
(10) Trainers shall teach a program on the use of restrictive interventions at least once annually.
(11) Trainers shall complete a refresher instructor training at least every two years.
(k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.
(1) Documentation shall include:
(A) who participated in the training and the outcome (pass/fail);
(B) when and where they attended; and
(C) instructor's name.
(2) The Division of MH/DD/SAS may review/request this documentation at any time.
(l) Qualifications of Coaches:
(1) Coaches shall meet all preparation requirements as a trainer.
(2) Coaches shall teach at least three times, the course which is being coached.
(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.
(m) Documentation shall be the same preparation as for trainers.

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This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure physical restraints were employed by trained staff for 1 of 10 staff (#3) and failed to ensure 5 of 10 staff (#2, #3, #4, #7, #9) demonstrated competency in the proper use of restrictive interventions. The findings are:

Review on 7/22/24 of staff #2's personnel record revealed:
- hire date: 6/9/23
- restrictive intervention: Handle with Care (HWC) expire 6/24/25

Review on 8/9/24 of staff #3's personnel record revealed:
- hire date: 11/1/22
- restrictive intervention: CPI (Crisis Prevention Institute) expired 9/30/23

Review on 7/22/24 of staff #4's personnel record revealed:
- hire date: 4/8/22
- restrictive intervention: HWC expire 6/24/25

Review on 8/9/24 of staff #7's personnel record revealed:
- hire date: 5/23/24
- restrictive intervention: HWC expire 6/24/25

Review on 8/9/24 of staff #9's personnel record revealed:
- hire date: 6/9/23
- restrictive intervention: HWC expire 6/24/25

Review on 7/22/24 of FC#5's record revealed:

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- age 12 years old
- admitted 10/11/23 and discharged 6/21/24
- diagnoses: Attention Deficit Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder

Review on 7/22/24 of FC#6's record revealed:
- age 10 years old
- admitted 5/9/24 and discharged 6/10/24
- diagnoses: Post Traumatic Stress Disorder (PTSD) and ADHD

Review on 7/25/24 of the facility's ABC data sheet for Former Client (FC#5 & FC#6) revealed the following:
- between 2/19/24 - 5/25/24 FC#5 was placed in 5 restraints
- FC#6 was placed in 1 restraint on 6/9/24

During interview on 7/19/24 staff #2 reported:
- she and staff #4 placed FC#5 in a restraint
- he had self injurious behaviors (SIB) and hit himself in the side of his head & threw objects
- could not recall much of the restraint, it happened in January or February 2024
- FC#5 was in a "face down restraint." Staff #4 held FC#5's arms & another hand on his shoulder. Could not recall how his face was positioned. FC#5 kicked and she crossed his legs. The restraint lasted less than 30 seconds

During interview on 7/22/24 & 7/31/24 staff #4 reported:
- FC#5 was upset this day but he could not recall why
- FC#5 threw items in his bedroom & had SIB
- he put FC#5 in a "T hold" with both hands crossed in front of him while he stood behind him. He (staff #4) assisted FC#5 to the floor because he was own his way down to the floor. He ended

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V 537	Continued From page 37 up on his stomach. He (staff #4) was on his knees beside FC#5 as FC#5 kicked. Staff #2 came in the bedroom and held his feet near the ankles. "FC#5 remained face down with his arms crossed in front of him for approximately 2 minutes." - Face down was a restraint trained by HWC During interview on 8/7/24 staff #3 reported: - had placed FC#5 in several restraints due to his behaviors - the restraint consisted of a "T" hold - he placed FC#5's arms in front of him while he held his wrist - the restraint lasted 2 -3 minutes - this was a NCI hold restraint - he was trained on the "T" hold from previous employment - he was aware the facility used HWC restrictive intervention During interview on 8/7/24 staff #7 reported: - she had placed FC#6 in a restraint in June 2024 - had a behavior in his bedroom and she had him sit in the kitchen with her - he began to stand and hit the table with his hands - she went behind him and placed his hands beside him until he calmed down - the restraint lasted less than 5 minutes During interview on 8/8/24 staff #9 reported: - 3 months ago he placed FC#6 in a restraint - FC#6 swung at him and he blocked the hit. He grabbed FC#6's wrist and placed both hands behind his back and "placed him face down." FC#6 kicked "all over the place." He (staff #9) was on his knees beside him. He was able to turn his face from side to side. The restraint lasted 15	V 537		

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V 537	Continued From page 38 minutes. - he could not think of the name of the restrictive intervention the facility used - he recalled the trainer came to the facility and taught them to block and "take down" a client During interview on 7/23/24 and 8/6/24 the Licensed Professional/Owner reported: - HWC restrictive intervention trained staff for "face down" restraints - the client must be able to turn their face from side to side - clients have to be able to breath - during the face down restraint, staff would hold the clients arms beside them and not crossed in front of the client - the restraint should last no more than 4 minutes - staff were trained in HWC however some staff were trained in NCI from previous employment During interview on 7/31/24 the Vice President (VP) of HWC reported: - clients' behaviors could be addressed by the clients hands placed above their heads with the staff's hands engaged on the clients' elbows. The staff would stand behind the client - At no time should a staff cross a client's arms in front of them or beside them - she would follow up with an email regarding face down restraints Review on 8/2/24 of an email sent to Division of Health Service Regulation (DHSR) from the VP of HWC revealed: - "...HWC does not teach the basket hold or any hold where the client's arms are crossed in front...we believe that the hold is from another training program (perhaps NCI (Nonviolent Crisis	V 537		

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Intervention) that does train the basket hold. However, the hold is not anything we/ HWC teaches. We have alerted Higher Aspiration (Licensee) that the basket hold is not a HWC hold and they are in agreement that it was not something taught or in HWC's program...Higher Aspiration is planning on attending a HWC training...in 2 weeks..."
- nothing documented in email regarding face down restraints

Review on 8/13/24 of the Plan of Protection dated 8/13/24 written by the LP/O revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? As of August 13, all staff will be instructed not to use any restrictive interventions laying face down for any of our residents. Staff will be formally notified until further notice about using alternative methods of restrictive interventions when handling resident. [LP/O] will also be attending a 3 day training for handle with care as well August 14-16. Describe your plans to make sure the above happens. The [LP/O] and [QP] will enforce this plan."

Clients' ages ranged from 10 - 12 years old with diagnoses of ADHD, Oppositional Defiant Disorder and Post Traumatic Stress Disorder. Staff failed to demonstrate competency when they placed clients in restraints. FC#5 was placed in a face down restraint with his arms crossed in front of him while staff #2 held his feet for 2 minutes. Staff #9 placed FC#5 face down with his arms behind his back for 15 minutes. Staff #4 restrained clients in a standing position by crossing their arms in front of them to address their behaviors. The facility's staff were trained in Handle with Care restrictive intervention curriculum, however some of the staff used NCI

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HIGHER ASPIRATION BEHAVIORAL HEALTH C	204 8TH STREET OXFORD, NC 27565

(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 537	Continued From page 40 restrictive intervention curriculum to restrain the clients. Based on staff not being trained in physical restraints that were approved as restrictive interventions, this deficiency constitutes a Type A2 rule violation for substantial risk of serious harm and must be corrected within 23 days.	V 537		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview the facility failed was not maintained in a attractive and orderly manner. The findings are: Observation on 7/19/24 at 1:53pm of the facility revealed: - the clients' bathroom had a missing shower knob - an empty bedroom had a hole the size of a baseball - client #1's bedroom closet wall had a hole size of a baseball During interview on 7/19/24 client #1 reported: - he and FC#6 horse played - FC#6 fell into the closet wall During interview on 7/19/24 staff #2 reported: - FC#4 broke the shower knob on 7/15/24 - maintenance was in route to fix the shower knob	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	240138	A. BUILDING: ______ B. WING ______	R-C 08/13/2024

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V 736	Continued From page 41 During interview on 7/19/24 the Qualified Professional reported: - FC#4 had a behavior and put a hole in the empty bedroom wall During interview on 7/19/24 the Licensed Professional/Owner reported: - will have the holes in the bedrooms repaired	V 736		
V 774	27G .0304(d)(7) Minimum Furnishings 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (d) Indoor space requirements: Facilities licensed prior to October 1, 1988 shall satisfy the minimum square footage requirements in effect at that time. Unless otherwise provided in these Rules, residential facilities licensed after October 1, 1988 shall meet the following indoor space requirements: (7) Minimum furnishings for client bedrooms shall include a separate bed, bedding, pillow, bedside table, and storage for personal belongings for each client. This Rule is not met as evidenced by: Based on observation and interview the facility failed to have minimum furnishings for a client bedroom which included separate bed, bedding pillow, bedside table. The findings are: Observation on 7/31/24 at 12:45pm of the facility revealed: - an empty client's bedroom turned into an	V 774		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 774	Continued From page 42 office - the bedroom had an office desk, a couch and a medication file cabinet During interview on 7/31/24 the Licensed Professional/Owner reported: - the Division of Health Service Regulation (DHSR) construction surveyor came out recently - the DHSR construction surveyor informed him the facility could only be licensed for 3 but needed to check building codes - until he heard back from the construction surveyor, the bedroom would remain an office	V 774		